REPORT OF
THE SECRETARY OF HEALTH AND HUMAN RESOURCES

STUDY OF HEALTH CARE-RELATED BOARDS IN THE COMMONWEALTH OF VIRGINIA WITH RECOMMENDATIONS FOR ACTION PURSUANT TO SJR 317 OF 1997

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Robert C. Metcalf
Secretary of Health and Human Resources

January 8, 1998

MEMORANDUM TO THE HONORABLE GEORGE ALLEN, GOVERNOR
and
THE GENERAL ASSEMBLY OF VIRGINIA

This report contained herein is pursuant to Senate Joint Resolution 317, passed by the 1997 General Assembly.

I am submitting this report as the results of the Study of Health Care-Related Boards in the Commonwealth of Virginia. The report contains the discussions and recommendations resulting from the study.

Respectfully submitted,

Robert C. Metcalf

Enclosure

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STUDY OF HEALTH CARE-RELATED BOARDS IN THE COMMONWEALTH OF VIRGINIA WITH RECOMMENDATIONS FOR ACTION PURSUANT TO SJR 317 OF 1997

Prepared By

Center for Public Policy Research
The Thomas Jefferson Program in Public Policy
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For the
Virginia Secretariat of Health and Human Resources

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The primary authors of this report are Dr. John McLaughlin, Research Associate; Paulette Parker, Research Analyst; Kelly Metcalf-Meese, Research Coordinator; and Dr. David H. Finifter, Director. Margaret Mahoney and Amanda Smith, Research Assistants for the Center and graduate students in The Thomas Jefferson Program in Public Policy, also helped complete this report. The content of this report does not reflect the views or opinions of the Center for Public Policy Research, The Thomas Jefferson Program in Public Policy, or The College of William and Mary, but rather those of its authors.

Preface

This study has been conducted under the authority of Senate Joint Resolution (SJR) 317 of the 1997 of the General Assembly. SJR 317 directed the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care (JCHC), to review the various health care-related boards, advisory boards, commissions, committees, and councils, (hereafter referred to as "boards") in the Commonwealth and make recommendations regarding any appropriate revisions, consolidations, or restructuring of these boards. This study builds upon the work completed by the Joint Commission on Health Care under SJR 104 of 1996. In addition, this study includes a comprehensive inventory of health policy-related entities that are composed of legislators or are appointed by the legislature, as well as a report of health care policy strategies in Georgia, Maryland, North Carolina, and Ohio.

The Secretary of Health and Human Resources assigned the Department of Medical Assistance Services (DMAS) as the lead agency for SJR 317. This study was contracted by DMAS to the Center for Public Policy Research of the Thomas Jefferson Program in Public Policy at the College of William and Mary. The authors of this report are Dr. John McLaughlin, Research Associate, Ms. Paulette Parker, Research Analyst, Ms. Kelly Metcalf-Meese, Research Coordinator, and Dr. David Finifter, Director. Margaret Mahoney and Amanda Smith, Research Assistants for the Center and graduate students in the Thomas Jefferson Program in Public Policy, also helped complete this project, as did Karen Dolan, Assistant to the Director at the Thomas Jefferson Program.

The authors would like to express their sincere gratitude to a number of people who contributed to the completion of this project. First, we would like to acknowledge those who laid the groundwork for this study. These include, Ms. Roberta Jonas, Legislative Coordinator of the Department of Medical Assistance Services, Mr. Jeff Wilson, Special Assistant, Office of the Secretary of Health and Human Resources, Ms. Kathryn Kotula, Director of the Policy Division of DMAS, and Mr. Patrick Finnerty, Senior Health Policy Analyst for the Joint Commission on Health Care. At the Department for Medical Assistance Services, Ms. Jonas has served as Project Coordinator for this study, and made herself available to us at each progressive stage of our work. In this capacity, Ms. Jonas has been exceptionally attentive and efficient in her responses to our various requests for data, while maintaining her equanimity and sense of humor in every circumstance.

The comprehensive nature of this study required the acquisition of information from many sources. The designated agency contacts and the individuals who have communicated with the Center for Public Policy Research either by memo, e-mail, fax, or phone, are too numerous to name. The importance of their contributions are immeasurable because they have permitted us to report and evaluate current information on the diverse group of health care-related entities included in this study. In addition, we would like to thank the health policy professionals with whom we spoke in Georgia, Maryland, North Carolina, and Ohio. By making inter-state comparison possible, their contributions greatly enhanced the breadth of this study.

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Executive Summary

Senate Joint Resolution (SJR) 317 of the 1997 Session of the General Assembly directed the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care (JCHC), to review the various boards, advisory boards, commissions, committees, and councils (hereafter referred to as boards) identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations or restructuring of these boards. The Virginia Department of Medical Assistance Services, which was designated as the lead agency, contracted with the Center for Public Policy Research of the Thomas Jefferson Program in Public Policy at the College of William and Mary to conduct this study. In completing this study and at the request of the Secretary, the goals of the study are as follows:

> Update the inventory resulting from a previous legislative study conducted by the Joint Commission on Health Care pursuant to SJR 104 of 1996 and make recommendations as to appropriate revision, consolidation, or elimination of the health care-related boards;
>
> Create a comprehensive inventory of all health policy-related entities that are composed of legislators or are appointed by the legislature; and,
>
> Investigate and report on the key issues related to the development of health care policy in Georgia, Maryland, North Carolina, and Ohio.

Findings and Recommendations

A. Update the Inventory Resulting From the Previous JCHC Study and Make Recommendations as to Appropriate Revision, Consolidation, or Elimination of Health Care-Related Boards

Our update includes 79 boards, including 16 additional boards not included in the prior JCHC study. Not surprisingly, the number of boards for each state agency varies widely, with the Department of Health and the Department of Health Professions having approximately 50 percent of the 79 boards responsible for health care-related issues in the Commonwealth. Below are the general findings and recommendations related to the boards. For the most part, this study concurs with the general conclusions reached by the previous JCHC study.

1. There is a Large Number of Boards.

In its study of the health care-related boards, the JCHC found that there is a large number of boards, and most, if not all, have specific constituencies, which support their mission and existence. The inventory update supports this conclusion. As before, nearly all the boards focus on specific health issues as opposed to broad health policy.

2. Representation of Citizens and Intra-Agency Representatives on Existing Boards Should Be Increased.

Of the 719 identifiable board members, 76 percent are professionals, consumers, or citizens. Our analysis demonstrates that while professional involvement on the boards is high, the representation of citizens and intra-agency representatives on the boards is fairly low. Of the 719 members on the existing boards, for example, only 49 members, seven percent of all members that can be identified, are citizens.

3. The Interaction Among Boards is Minimal and Informal.

This study concurs with the prior JCHC study finding that there is minimal formal interaction and networking among the boards. However, there is some indication from agency contacts that informal interaction may be taking place. This interaction occurs through three avenues: individuals may serve on several boards, agency employees staff more than one board, and board membership may include representatives from several agencies.

To encourage more interaction among Virginia's boards, the following actions are recommended:

Create opportunities for formal networking of existing boards.

Revise the Code of Virginia to require boards to collaborate, where appropriate.

Direct the Secretary of Health and Human Resources to design a mechanism and appropriate incentives that lead to the sharing of information across boards.

4. Most Boards Should Remain Unchanged.

Of the 79 boards identified in this study, we recommend that 62, or 78 percent, of the Commonwealth's boards remain unchanged. In short, these boards are functioning as intended. Although the boards may not be interacting with each other nearly enough, they have clear missions, are working to perform their missions as identified in the Code of Virginia, and meet regularly as directed by their enabling legislation. There are several other boards that are not meeting regularly that we recommend keeping, including those boards that are new and have not yet had an initial meeting.

5. Two Boards Under the Department of Professional and Occupational Regulation Should be Reassigned to the Department of Health Professions.

The Board for Opticians and the Board for Hearing Aid Specialists under the Department of Professional and Occupational Regulation should be moved to the Department of Health Professions given their functions.

6. **Six Boards Should Be Eliminated, Because They Are No Longer Necessary--They Are No Longer Functional and/or Their Missions Are Currently Carried Out By Other Boards in the Commonwealth.**

We recommend eliminating six of the Commonwealth's existing boards while recognizing that their elimination may take away important opportunities for citizen input into government decision making. None of these boards are currently functioning -- they do not meet and their functions have been taken over, or are duplicated by other boards. These boards include the following:

Department of Health: Home Care Services Advisory Committee and AIDS Advisory Board

Department for the Aging: Specialized Transportation Council and Specialized Transportation Technical Advisory Committee

Department of Medical Assistance Services: Advisory Committee on Medicare and Medicaid

Interagency: Interagency Coordinating Council on Housing for the Disabled

7. **The Virginia Council on Coordinating Prevention and the State Executive Council for At-Risk Youth and Families Should Be Consolidated.**

Given the need for prevention to deal with at-risk youth and families, many state contacts recommended that rather than breathing new life into the Virginia Council on Prevention, its functions should be consolidated into the State Executive Council. This will likely require new legislation that would expand the mission and duties of the State Executive Council.

8. **Further Study Must Be Done to Determine Whether Seven Boards Are Necessary.**

There are seven boards where further study is needed before any recommendation as to no action, elimination, or consolidation can be made. In these cases, study as to either, the boards' appropriateness, use, interaction with the State or other boards, and effectiveness, is necessary. With regard to the Regional Health Planning Agencies/Boards, we recommend that further study be conducted with the goal of ascertaining the mechanisms in place by which the Regional Boards have the capacity to impact State level planning. It is our assessment that the five Regional Boards are functioning productively, and that there is effective communication among them.

The boards recommended for further study include the following:

Department of Health: Virginia Health Planning Board

Department of Health: Regional Emergency Medical Services Councils

Department of Health: Regional Health Planning Agencies/Boards

Department of Health Professions: Psychiatric Advisory Board

Department of Mental Health, Mental Retardation, and Substance Abuse Services: Governor's Council on Alcohol and Drug Abuse Problems

Department of Mental Health, Mental Retardation, and Substance Abuse Services: Alzheimer's Disease and Related Disorders Commission

Department of Medical Assistance Services: Medicaid Prior Authorization Advisory Committee

9. Consideration Should Be Given to Linking Local School Health Boards to an Existing State Board.

Discussions indicate that the local School Health Boards report directly to the Departments of Health and Education. There is currently no state board to which the local boards report. Interviewees indicated their support for establishing a new state school health board. Rather, we recommend investigating the possibility of linking the local boards to an existing board, such as the Board of Health or the Board of Education.

B. Create a Comprehensive Inventory of All Health Policy-Related Entities That Are Composed of Legislators or Are Appointed By the Legislature

There are 21 legislative entities that involve some aspect of health care policy. Their missions range from overseeing the administrative procedures for the various local driver alcohol rehabilitation programs to making recommendations on the delivery of mental health services and studying the health problems of African-American males. The membership on these boards consists primarily of legislators (62 percent) and professionals (25 percent).

C. Investigate and Report on the Ways in Which Georgia, Maryland, North Carolina, and Ohio Develop Health Care Policy

All states interviewed utilized boards and councils to form health care policy and to monitor and advise government on health care issues. Most of these were established through code, and most have no sunset provisions. Several were formed as a result of federal requirements, but many are established to give a particular constituency (e.g., persons with disabilities) a voice in government or to address a specific issue (e.g., transportation and housing).

As in Virginia, the Governor and legislature of these states have attempted to reduce the number of the boards. However, even though they are narrowly defined, the boards and councils do represent an opportunity for citizen participation, as well as an opportunity for political patronage. Furthermore, relatively few resources are required to operate the boards, given the opportunity for public involvement. As such, the reductions have been minimal.

Most states reported that there were few regulatory or policy making boards, usually one per agency. The majority of the boards are advisory.

Study of Health Care-Related Boards in the Commonwealth of Virginia with Recommendations for Action Pursuant to SJR 317 of 1997

I. Authority and Goals for the Study

Senate Joint Resolution (SJR) 317 of the 1997 Session of the General Assembly directed the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care (JCHC), to review the various boards, advisory boards, commissions, committees, and councils (hereafter referred to as "boards") identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations or restructuring of these boards. In completing this study and at the request of the Secretary, the goals of the study are the following:

- Update the inventory resulting from a previous legislative study conducted by the Joint Commission on Health Care pursuant to SJR 104 of 1996 and make recommendations as to appropriate revision, consolidation, or elimination of the health care-related boards;

- Create a comprehensive inventory of all health policy-related entities that are composed of legislators or are appointed by the legislature; and,

- Investigate and report on the key issues related to the development of health care policy in Georgia, Maryland, North Carolina, and Ohio.

A copy of SJR 317 is provided in Appendix 1.

II. Background

Health care reform is one of the major driving forces leading to the review and improvement of health care policies, procedures, and resource bases in states throughout the nation. States are facing the challenges of seeking new avenues by which to increase access to health care for all citizens and, at the same time, reduce the costs of those services. In Virginia, several administrative, legislative, and study actions have been, or are currently, being taken to address growing concerns about access and the cost of health care. One important step in this process is the review of the various boards that have health-related missions authorized and administered through the executive and/or legislative branches of state government.

In 1996, Senate Joint Resolution 104 directed the Joint Commission on Health Care, in consultation with the Secretary of Health and Human Resources, to conduct a preliminary review

of the various boards having an association with health care policy and service delivery in Virginia. That study concluded that there were 63 health care and health-related boards that had specific constituencies that support their mission and existence.[1] Furthermore, the study found that, while major health care agencies believe that the structure and procedures of the various health-related boards are appropriate, several boards had not met for quite a long time, and there was little apparent interaction among the boards.

After reviewing the JCHC report, in 1997 members of the Virginia General Assembly promulgated SJR 317 (see Appendix 1 for the complete text of SJR 317). The resolution requested

> [T]he Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care, to review the various boards, advisory boards, commissions, committees and councils identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations or restructuring of these entities.

In addition to seeking opportunities to revise, consolidate, or restructure these boards, SJR 317 recognized that some boards may need to be abolished because the need for their existence was no longer apparent. The central focus of the present study is to build upon the past JCHC report and respond to the request in SJR 317.

The importance of the study is underscored in a letter from Secretary Robert C. Metcalf to Senator Stanley C. Walker, chairperson of the JCHC (see Appendix 2). In that letter, the Secretary points out that Executive Order Number One (94) charged the Governor's Commission on Government Reform to review, among other things, all boards and commissions, "to determine those that best serve the needs of Virginians and to abolish or consolidate those boards that were unnecessary or duplicative." The Secretary further noted that, while the boards serve as one means to decentralize government decision making, they provide an essential opportunity for citizen and professional involvement in state government. Thus, when examining alternatives to reduce the number of boards, it is important to protect the opportunities for citizen participation.

Another theme emphasized by Secretary Metcalf in his letter is the importance of collaboration and cooperation among the various boards. Recognizing that the lack of collaboration may be due to a number of factors, such as the specific missions of the boards and/or the lack of clear instruction to collaborate, the Secretary suggested that, when appropriate, such collaboration could enhance the health mission of the Commonwealth. However, the Secretary cautioned that collaboration should in no way impede the boards' ability to perform their principal statutory obligation.

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[1] Commonwealth of Virginia, Joint Commission on Health Care, Study of the Various Entities Receiving State Funds or Having Responsibilities for Health Care Policy and Regulations Pursuant to SJR 104 of 1996, Senate Document No. 8 (Richmond, Virginia: 1997).

III. Study Questions

The following questions provided direction for the design, conduct, interpretation, and report of the study's three requirements:

1. What boards presently exist in state government that have a health-related mission or function?

2. Which of these boards, if any, should be restructured, consolidated, or abolished?

3. What is the current state of "networking and collaboration" among existing boards?

4. What are the thoughts, perceptions, and ideas of representatives of health-related agencies in Georgia, Maryland, North Carolina, and Ohio?

IV. Data Collection and Analysis

The starting point for this study was the inventory of boards created by the Joint Commission on Health Care pursuant to SJR 104 of 1996. JCHC staff identified 63 health care and health-related boards and categorized each by name of entity, code authority, mission/purpose, number of members, member composition, appointing authority, and meetings. To update the JCHC inventory and fulfill the study's other requirements noted earlier, several methods were used.

A. Update the JCHC Inventory and Make Recommendations as to Appropriate Revision, Consolidation, or Elimination of Health Care-Related Boards

The bulk of the data collection for updating the previous JCHC inventory occurred through interviews with agency contacts (see Appendix 3). In a July 9, 1997 memo, Secretary Metcalf directed all agency contacts to update the JCHC inventory, indicating any changes to the roles, responsibilities, functions, or duties of the boards as appropriate (see Appendix 4). Agency contacts sent responses, which are incorporated in the present study (see Appendix 5). Staff from the Center for Public Policy Research (CPPR) then made follow-up phone calls to all contacts to gather further information about boards identified by the JCHC in its earlier report and those boards that were newly identified. In addition, Center staff reviewed the 1996-1997 Report of the Secretary of the Commonwealth to the Governor and General Assembly of Virginia. For those boards not yet included in the JCHC inventory, Center staff obtained information related to the new boards' code authority, mission/purpose, number of members, member composition, appointing authority, and meeting schedules. For all boards, Center staff obtained the number of recent meetings to determine how active the boards actually were (see Appendix 6).

Like the earlier JCHC inventory, this inventory does not include a comprehensive listing of all advisory committees and councils created by many state agencies to provide internal input and advice on health care-related issues, nor does it include private, not-for-profit boards involved in health care. The 79 boards in this inventory were included because they are located in the executive branch and their missions involve some aspect of health care. In certain cases, the boards' primary mission/purpose includes health care but only in a limited or narrow way. It is possible that not all boards are included in the updated inventory, but we have included all such boards known to us at this time.

Boards that were reviewed for possible revision, consolidation, or elimination included two groups: 1) boards that did not meet at all or did not meet as frequently as required in the Code and 2) boards identified by agency contacts for possible action. From these two groups, Center staff made recommendations as to whether a board should remain or some sort of action, such as revision, consolidation, or elimination, should be taken. It is beyond the scope of this study to evaluate the appropriateness, use and effectiveness of each board. However, descriptive statistics are provided on the boards' membership composition, focusing on the involvement of consumers, citizens at-large, professionals, interagency representatives, intra-agency representatives, and regional representatives. The report also includes an analysis of the networking and collaboration that occurs among the various boards.

B. Create a Comprehensive Inventory of All Health Policy-Related Entities that are Composed of Legislators or are Appointed by the Legislature

To create an inventory of health policy entities composed of legislators or appointed by the legislature, Center staff reviewed information from the Division of Legislative Services and from the Secretary of the Commonwealth's last two reports. For each legislative entity, information was obtained on the entity's legislative classification, authorizing code or bill, mission/purpose, possible link to executive branch boards, member composition, and duration. Given the study's goals, no recommendations were made to revise, consolidate, or eliminate these legislative entities. Moreover, it is beyond the scope of this study to review health care studies being conducted in the Commonwealth; our focus is on legislative organizations, not legislative activities such as studies.[2]

C. Investigate and Report on the Ways in Which Georgia, Maryland, North Carolina, and Ohio Develop Health Care Policy

To gather data on the ways in which four select states develop health care policy, staff from the Center for Public Policy Research contacted at least two individuals from each state (see Appendix 7) and reviewed each state's web site (see Appendix 8). The analysis provided later in this report focuses on the states' answers to the following questions:

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[2] An example of a legislative study that we excluded is one that required the Board of Health Professions to study the appropriate criteria used in determining the need for regulation of any health care occupation or profession.

1. What is the relationship between the major health care-related agencies?

2. What are the major issues faced by health planners?

3. What is the role played, if any, in the formation, implementation, and/or monitoring of health care policy by advisory boards and councils?

4. What role, if any, does the federal government play in the formation of health policy?

5. What are the key factors that influence successful health planning in your state?

V. Findings and Recommendations

As noted earlier, this study has three primary purposes: 1) Update the inventory resulting from a previous JCHC study and make recommendations as to appropriate revision, consolidation, or elimination of health care-related boards; 2) create a comprehensive inventory of all health policy-related entities that are composed of legislators or are appointed by the legislature; and 3) investigate and report on the ways in which selected states -- Georgia, Maryland, North Carolina, and Ohio -- develop health care policy. The sections below address each study goal in turn.

A. Update the Inventory Resulting From the Previous JCHC Study and Make Recommendations as to Appropriate Revision, Consolidation, or Elimination of Health Care-Related Boards

Table 1 is an update of JCHC's inventory of health care-related boards in the Commonwealth of Virginia. This update includes 79 such boards, including 16 additional boards not included in the prior JCHC study (see Table 2).[3] For each board, Table 1 provides information on the board's code authority, mission/purpose, number of members, member composition, appointing authority, required meetings, and actual recent meetings.

Not surprisingly, the number of boards for each state agency varies widely with the Department of Health and the Department of Health Professions having approximately 50 percent of the 79 boards responsible for health care-related issues in the Commonwealth. Other state agencies, such as the Department of Medical Assistance Services, Department of Rehabilitative Services, Department for the Visually Handicapped, Department for the Aging, and the Department of Mental Health, Mental Retardation, and Substance Abuse Services, have at least three boards under their purview.

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[3] This updated inventory includes all the boards contained in the previous JCHC inventory except one: the Department for the Aging's Long-Term Care Council which expired on July 1, 1995.

Some of the boards' missions are directly related to health care issues. For example, the Department of Health's Board of Health (#1 in Table 1) mission is to provide leadership in health planning and policy for the Commonwealth. Other boards' missions are only indirectly related to health care. For example, the mission of the Department of Aging's Specialized Transportation Council (#70 in Table 1) is to support the development of safe, cost-effective, coordinated and specialized transportation services for the elderly and disabled.

Below are the general findings and recommendations related to the boards. For the most part, this study concurs with the general conclusions reached by the previous JCHC study.

1. There is a Large Number of Boards.

In its study of the health care-related boards, the JCHC found that there is a large number of boards, and most, if not all, have specific constituencies, which support their mission and existence. The inventory update supports this conclusion. As before, nearly all the boards focus on specific health issues as opposed to broad health policy, and most have constituencies that rely on the board's existence for participation in the decision-making process. In addition to serving constituencies, the boards focus on service delivery or support services.

2. Representation of Citizens and Intra-Agency Representatives on Existing Boards Should Be Increased.

As noted earlier, boards provide an essential opportunity for citizen and professional involvement in state government (see Appendix 2). As shown in Table 3, our analysis shows that these groups do indeed have representation on the boards. Of the 719 identifiable board members, for example, 76 percent are professionals, consumers, or citizens. However, our analysis also demonstrates that while professional involvement on the boards is high, the representation of citizens and intra-agency representatives on the boards is fairly low (see Table 3 for the summary breakdown and see Appendix 9 for a breakdown of each board's constituency profile). More specifically, of the 719 members on the existing boards, only 49 members, seven percent of all members that can be identified, are citizens. Only eight members are intra-agency representatives. Almost half of identifiable members are professionals. In fact, 18 boards have members of only professionals, while only three have citizens or consumers only (see Table 4).

3. The Interaction Among Boards is Minimal and Informal.

In its report to the General Assembly, the JCHC found, among other things, that there was "very little interaction among the various health boards, commissions, committees, and councils." Unfortunately, the apparent lack of interaction among boards can lead to fragmentation or an image of fragmentation in the health service delivery system. This study concurs with the JCHC's finding that there is minimal formal interaction and networking among the boards. However, there is some indication from agency contacts that informal interaction may be taking place. This interaction occurs through three avenues: individuals may serve on several boards, agency employees staff more than one board, and board membership may inclu

representatives from several agencies.

Individuals who serve on more than one board are able to share information and products with other members on those boards in which they have joint membership. Agency staff also facilitate interaction among the boards by providing support to more than one board for which the agency is responsible. This study's review of boards found that most agencies have one policy making board, such as the Board of Health (#1 in Table 1) and several advisory boards. In most cases, the advisory boards provide the necessary information for policy formation as well as monitoring of policy implementation. Agency staff provide support to these boards and often interact with each other regarding the work of the particular board for which they are responsible.

In other cases, representatives from several agencies are members of the same boards. For example, the Virginia Board for People with Disabilities (#57 in Table 1) has representatives from nine state agencies, as well as others representing numerous consumer groups and service providers. In this case, staff from the different agencies on the Board consult on a regular basis. Because these staff serve other boards within their own organizations, it is likely that information and products are shared across boards. As another example of interagency networking, each school division in Virginia has a School Health Advisory Board (#72 in Table 1) staffed by personnel from the Department of Education and the Department of Health. From these Boards, one of the persistent requests has been for help in developing relationships between them. As a result, one of the foci of board training, which will conducted this year by staff of the Department of Education and the Department of Health, will be inter-board communication and exchange.

Clearly, there is great potential for interaction among the boards reviewed in Table 1, particularly because, while all have a common health-related thread, several have common or even overlapping missions. For example, the Board of Audiology and Speech Pathology (#21 in Table 1) and the Board for Hearing Aid Specialists (# 74 in Table 1) clearly have similar target client groups. While the Board of Audiology and Speech Pathology is affiliated with the Department of Health Professions, the Board of Hearing Aid Specialists is part of the Department of Professional and Occupational Regulation. In responding to the request for information for this study, the Director of the Department of Professional and Occupational Regulation recommended that the Board for Hearing Aid Specialists be reassigned to the Department of Health Professions. Based on the commonality of the areas addressed by these two Boards, we concur with this recommendation.

Unfortunately, our review found that, in some cases, agency staff were not aware that an existing board had a mission similar to the one that he or she staffed. Interaction between these boards could enable the boards to more effectively and efficiently achieve their individual missions, and, perhaps, help the boards achieve goals they would not be able to achieve on their own. Connecting the current boards could be pursued through both formal and informal means, and lead to improved understanding of what individual boards are trying to accomplish. Most boards collect information in the conduct of their duties. Because of the similarity of missions across boards, it is apparent that the information collected by one board might be of use to

another. Advice and/or policies offered by one board, in most cases, likely will affect another board of similar mission. Without more formal interaction among the boards, consumers, health care providers, and other constituencies who wish to have input to or profit from the activities of board actions must attend several meetings to achieve their purpose.

To encourage more interaction among Virginia's boards, the following actions are recommended:

- **Create opportunities for formal networking of existing boards.** We recommend that mechanisms be established to enable formal networking and, where appropriate, collaboration among boards of like mission. Simply mailing a copy of this legislative study to all existing boards would be an excellent start. Because several boards collect information to support their decision making, it seems reasonable to expect that the boards work together to design, conduct, and report information.

- **Revise the Code of Virginia to require boards to collaborate, where appropriate.** As mentioned earlier, most agencies have one policy board and several advisory boards. Given the similar missions of these boards (see Table 1), they should collaborate on a regular basis to enhance the individual boards' contribution to the overall mission of the agency.

- **Direct the Secretary of Health and Human Resources to design a mechanism and appropriate incentives that lead to the sharing of information across boards.** Planning and delivery of health services at the point-of-service are becoming more systemic, integrated, and collaborative. Fortunately, the Secretary of Health and Human Resources is providing leadership in the coordination of health care services through the bimonthly meetings of all agency heads. Notwithstanding, we recommend the development of an improved network of the boards that will facilitate the formulation of policy and provide advice regarding health care services.

4. Most Boards Should Remain Unchanged.

As with the JCHC study, most agency contacts believe that the current number, structure, mission, and functions of their respective boards are appropriate. For this reason, they recommend no actions be taken to revise, eliminate, or consolidate their boards. For the most part, this study concurs. Of the 79 boards identified in Table 1, for example, we recommend that 62 or 78 percent of the Commonwealth's boards remain unchanged (see Table 5). In short, these boards are functioning as intended. Although the boards may not be interacting with each other nearly enough, they have clear missions, are working to perform their missions as identified in the Code of Virginia, and meet regularly as directed by their enabling legislation.

There are several boards that are not meeting regularly that we recommend keeping. The first group includes those boards that are new and have not yet had an initial meeting. These include the Department of Health's Commonwealth Neurotrauma Initiative Advisory Board (#18 in Table 1) and the Department of Health Professions' Intervention Program Committee (#34 in Table 1). In addition, we recommend maintaining the Department of Health's Human Research Review Committees (#8 in Table 1) even though they are currently inactive. According to our contacts, the need as defined in the Code for these committees continues to exist. We agree with the agency contact that "there have been no changes to the mandated roles, responsibilities, functions or duties of the Human Research Review Committees" and that the Committees are necessary "to ensure protection of the rights and welfare of human research participants should research be initiated in the future" (see Appendix 5).

5. Two Boards Under the Department of Professional and Occupational Regulation Should be Reassigned to the Department of Health Professions.

Two boards under the Department of Professional and Occupational Regulation should be moved to the Department of Health Professions:

- Board for Opticians (#73 in Table 1)
- Board for Hearing Aid Specialists (#74 in Table 1)

According to the Director of the Department of Professional and Occupational Regulation, these boards would be more appropriately placed within the Department of Health Professions, given their functions (see Appendix 5). In the words of the Director of the Department of Professional and Occupational Regulation, the Board for Opticians "directly relates to the practice of optometry and ophthalmology," and the Board for Hearing Aid Specialists more logically relates to the "practice of audiology and otolaryngology." The Department of Health Professions has expressed concerns about the possible addition of these two boards to the Department.

It is evident that the optimal means of handling this possible change is not intuitively obvious to all the parties involved. If the Board for Opticians and the Board for Hearing Aid Specialists were moved, the Department of Health Professions would be required to integrate them into the training done by its Enforcement Division. Given that the Enforcement Division of the Department of Health Professions is currently addressing a backlog in excess of 4,000 cases, however, careful consideration should be given to whether the Department of Health Professions will require additional resources in order to successfully adopt the additional regulatory responsibility.

6. Six Boards Should Be Eliminated, Because They Are No Longer Necessary--They Are No Longer Functional and/or Their Missions Are Currently Carried Out By Other Boards in the Commonwealth.

The previous JCHC legislative study recommended possible elimination of only one

board, the Virginia Health Planning Board. Using the data gathered from the agency contacts for the updated inventory and the Secretary of the Commonwealth's Report, we recommend eliminating six of the Commonwealth's existing boards while recognizing that their elimination may take away important opportunities for citizen input into government decision making (see Table 6). None of these boards are currently functioning -- they do not meet and their functions have been taken on or are duplicative of other boards.

Department of Health: Home Care Services Advisory Committee and AIDS Advisory Board

The Department of Health's Home Care Services Advisory Committee has not met in a decade (#7 in Table 1), and the Department's AIDS Advisory Board (#13 in Table 1) has not met for several years. In both cases, the functions of these boards are currently being addressed by other boards. The Virginia Association for Health Care has taken on the responsibilities of the Home Care Services Advisory Committee, while the HIV Community Planning Committee (#14 in Table 1) and the AIDS Drug Assistance Program (#15 in Table 1) are doing the work of the AIDS Advisory Board. For these reasons, we recommend the elimination of the Home Care Services Advisory Committee and the AIDS Advisory Board.

Department for the Aging: Specialized Transportation Council and Specialized Transportation Technical Advisory Committee

The Department for the Aging's Specialized Transportation Council (#70 in Table 1) and Specialized Transportation Technical Advisory Committee (#71 in Table 1) have not met regularly. The Specialized Transportation Council, for example, has not met during the past year, and between 1993 and 1996, it met only four times. The Specialized Transportation Technical Advisory Committee has not met for approximately three years. Since the functions of these boards do not appear vital to the health mission of the Commonwealth as evidenced by the lack of meetings, we recommend their elimination. With the elimination of these two entities, the Commonwealth may want to address the coordination of strategy for human service transportation for the elderly and disabled by some other means.

Department of Medical Assistance Services: Advisory Committee on Medicare and Medicaid

The Department of Medical Assistance Services' Advisory Committee on Medicare and Medicaid (#42 in Table 1) is not needed (see Background Paper in Appendix 5). Its mission is duplicative of the mission for the Board of Medical Assistance Services, which was created in 1985 (#41 in Table 1). Moreover, the Advisory Committee on Medicare and Medicaid has not met since June 1991, and all the appointments for members of the Committee have expired.

Interagency: Interagency Coordinating Council on Housing for the Disabled

The Interagency Coordinating Council on Housing for the Disabled (#65 in Table 1) has

not met in three years according to agency contacts in the Virginia Board for People with Disabilities and the Department for Rights of Virginians with Disabilities. Given that this Council is no longer fulfilling its intended mission as evidenced by the lack of meetings, we recommend its elimination.

7. The Virginia Council on Coordinating Prevention and the State Executive Council for At-Risk Youth and Families Should Be Consolidated.

Most state agency contacts believed that prevention is a very important issue for the Commonwealth. However, many noted that the Virginia Council on Coordinating Prevention (#64 in Table 1) had not met for seven years and that prevention is not being adequately addressed by the State Executive Council for At-Risk Youth and Families (#63 in Table 1).

Given the need for prevention to deal with at-risk youth and families, many state contacts recommended that rather than breathing new life into the Virginia Council on Prevention, its functions should be consolidated into the State Executive Council. This will likely require new legislation that would expand the mission and duties of the State Executive Council.

8. Further Study Must Be Done to Determine Whether Seven Boards Are Necessary.

There are seven boards where further study is needed before any recommendation as to no action, elimination, or consolidation can be made (see Table 7). In every case, a study as to the boards' appropriateness, use, and effectiveness, is necessary.

Department of Health: Virginia Health Planning Board

The inactivity of the Virginia Health Planning Board (#5 in Table 1) presents to the Secretary of Health and Human Resources and the Virginia General Assembly, one of the pressing current issues in health care policy in Virginia. The Virginia Health Planning Board is the only health care-related board established in the Code, which is designated as supervisory. All others are either advisory or policy boards. If operational, this Board has the potential to function as the State's "Superboard" with regard to supervising coordination of the development and implementation of health care policy. However, experience of the past several years, during which the Board has become non-functional, indicates that the functions originally assigned to this Board are now being fulfilled through the Secretariat. At the present time, for example, the Secretary of Health and Human Resources holds bimonthly meetings of all agency heads as a means of coordinating health services throughout the Commonwealth.

Discussion of the Virginia Health Planning Board is not new. The JCHC study, for example, reported that the Board had not met in several years. The question of whether the Virginia Health Planning Board should, or should not, be reactivated, is a far-reaching one with broad implications for the strategy of how Virginia wishes to coordinate the development and

implementation of state health care policy. This issue requires careful study.

Department of Health: Regional Emergency Medical Services Councils

In a memo dated July 18, 1997, Dr. Randolph Gordon, State Health Commissioner, reports that the Office of Emergency Medical Services (OEMS)

> strongly recommends the adoption of regulations as required by the Code. It also recommends a review of current designated regional councils and restructuring as appropriate. Included in the review should be alternatives for realignment of service areas, staffing, and contractual requirements between regional OEMS and the regional councils, and an analysis of the State positions (FTEs) needed to comply with the established performance standards. OEMS believes that information from such a review could enable it to improve the efficiency and efficacy of its operations as they pertain to the regional EMS councils. (See Appendix 5)

In view of these suggestions, we agree that further study of the Regional Emergency Medical Services Councils is warranted. The OEMS has already developed draft regulations, a Designation Process Manual, and performance standards. Evaluation of these documents could serve as the starting point for a future study.

Department of Health: Regional Health Planning Agencies/Boards

The rationale for placing the Regional Health Planning Agencies/Boards in the category of further study is to encourage a closer look at the mechanisms in place for facilitating interaction between these regional agencies/boards and State level boards and agencies. Our research, conducted through several contacts at the Virginia Department of Health, with input from the current coordinator of the Boards, confirmed the effective functioning of the five Regional Boards. Each of the Regional Boards meets frequently, from four to 12 times per year; their membership is stipulated at less than 30. The impact of the de facto absence of the Virginia Health Planning Board on the Regional Boards requires further study.

The Regional Health Planning Boards were initiated in the mid 1970s under Federal legislation. In 1989, the founding legislation was supplemented by State mandate, which provided for the continuance of Virginia's Regional Boards in the face of decreasing Federal dollars. Currently, the Regional Health Planning Boards are integrally involved in the State's Certificate of Need Program. In this capacity, the Regional Boards hold public hearings from which recommendations are made to the Board of Health. This is one channel through which the Regional Boards report to the State. A second function of the Regional Boards is participation in the primary care resources programs of the Virginia Department of Health. As an enabling document, there is a Memo of Understanding between the Regional Boards and the Virginia Department of Health defining the Boards' roles and responsibilites.

It is our assessment that networking among the five Regional Boards is functioning

effectively. The Directors, or a representative from each of the five Boards, meet together every two weeks, either in Richmond or Charlottesville. One of the Directors functions as a coordinator among the five Boards, with this position rotating amongst the Boards. This leads us to believe that communication between the Regional Boards is effectual and productive. In addition, the Regional Boards' functions, cited above, in terms of involvement with the Certificate of Need Program, and the primary care resources programs, bring them into regular contact with several divisions within the Virginia Department of Health. Accordingly, we recommend that further study be done in order to ascertain whether the current mechanisms of communication with State level entities are adequate to fully utilize the information being generated by the Regional Health Planning Boards.

Department of Health Professions: Psychiatric Advisory Board

The Department of Health Professions' Psychiatric Advisory Board (#25 in Table 1) was initially created to examine persons licensed or seeking licensure and to advise the Board of Medicine on mental or emotional condition of such persons. For the past several years, however, it has been difficult to get members to serve on this board. According to agency contacts, the work of the Board had become "saddled with conflicts of interest." As a result, the Board has hired expert witnesses who testify before the Board about practitioners who have mental or emotional conditions. Within this context, the Psychiatric Advisory Board became non-functional. However, it appears that this board, or some modification of it, is needed; the board continues to serve an important function -- instead of relying on its members, it relies on expert witnesses. Further study of this board is needed.

Department of Mental Health, Mental Retardation, and Substance Abuse Services: Governor's Council on Alcohol and Drug Abuse Problems

The Governor's Council on Alcohol and Drug Abuse Problems (#48 in Table 1) has not met in four years. However, a Joint Subcommittee is currently reviewing the need for this Council.

Department of Mental Health, Mental Retardation, and Substance Abuse Services: Alzheimer's Disease and Related Disorders Commission

The Alzheimer's Disease and Related Disorders Commission (#47 in Table 1) was created to develop a plan for funding initiatives to victims of Alzheimer's disease and other related disorders. For the past four years, however, the Commission has not met, and it has no current members. With almost half of the Commission members representing consumers, it appears that the Alzheimer's Disease and Related Disorders Commission provides an important opportunity for victims of the disease to participate in governmental decisions that affect their lives. Certainly, the functions of the Alzheimer's Disease and Related Disorders Commission of the Department of Mental Health, Mental Retardation, and Substance Abuse Services could be consolidated into the functions of the Department of Aging, given its mission. However, by doing so, Alzheimer's victims have less ability to participate in the governmental process.

Further study is required before such a decision is made.

Department of Medical Assistance Services: Medicaid Prior Authorization Advisory Committee

The Medicaid Prior Authorization Advisory Committee (#43 in Table 1) was created to review prescription drug products and make recommendations for those drugs which require prior authorization. However, the Committee members declined to make these recommendations because of the constraints imposed by the rules governing their actions. The process surrounding prior authorization is seen by many as being unduly cumbersome and in need of reform. The Department has committed to working with the pharmacy community to identify ways of improving the process, with the goal of recommending changes to the process during the 1999 legislative session.

9. Consideration Should Be Given to Linking Local School Health Boards to an Existing State Board.

According to representatives of the Department of Education, the School Health Advisory Boards are found in all school divisions. The Boards are independent and are not responsible to any local agency. As such, communication and networking among boards are informal at best. Several board representatives have asked for training and assistance directed at facilitating communication and collaboration across boards. We support the need for such training and assistance efforts.

Discussions indicate that the local School Health Boards report directly to the Departments of Health and Education. There is currently no state board to which the local boards report. Interviewees indicated their support for establishing a new state school health board. Having such a board would allow for the establishment of consistent policies and procedures for the local boards to follow. The new boards also could assess state needs and prepare strategic plans to address these needs through the local boards. While it is recognized that there would be substantial benefit to local boards to have a state board to which it could relate, forming a new board may not be cost effective. Rather we recommend investigating the possibility of linking the local boards to an existing board, such as the Board of Health or the Board of Education.

B. Create a Comprehensive Inventory of All Health Policy-Related Entities That Are Composed of Legislators or Are Appointed By the Legislature

The second goal of this study is to create a comprehensive inventory of all health policy-

related entities that are composed of legislators or are appointed by the legislature.[4] Table 8 provides such an inventory. Because these legislative entities provide important input to health care policy and regulation in the Commonwealth, it is important to know what they are and if they have any possible links to boards, commissions, committees, and councils in the executive branch. We have included information on each legislative entity's mission/purpose, possible linkage to executive branch boards, composition of the entity, and its duration.

As seen in Table 8, there are 21 legislative entities that involve some aspect of health care policy. Their missions range from overseeing the administrative procedures for the various local driver alcohol rehabilitation programs to making recommendations on the delivery of mental health services and studying the health problems of African-American males. The membership on these boards consists primarily of legislators (62 percent) and professionals (25 percent) (see Table 9). Membership on these boards brings legislators into contact with the Executive branch.

C. Investigate and Report on the Ways in Which Georgia, Maryland, North Carolina, and Ohio Develop Health Care Policy

The final study goal is to gather information from four selected states to determine how they develop health care policy. We focused on five questions, which are discussed in turn below.

1. What is the relationship between the major health care-related agencies?

Of the four states contacted, three -- Maryland, North Carolina, and Ohio -- had two primary agencies, health and social services, responsible for health care. In these states, one agency generally had responsibility for the development of policies and procedures for Medicare and Medicaid payments. Interestingly, North Carolina, is in the process of merging the functions of its two lead health agencies under one agency to better reflect the systemic design and delivery of health care at the local level. A further driving force is the need for state leadership at a time when health care reform is rapidly emerging. Our North Carolina contacts indicated that the state had a need at this time for "one voice" in the purchasing, monitoring, and delivery of services. The proposed merger will provide better opportunity for collaboration and cooperation within the state-level departments and programs and provide a more consistent and cohesive response to local initiatives.

Other states have chosen not to merge their health care agencies, because they believed health policy and planning may lose its voice to the issue of health care costs. Several state contacts suggested that they would have to review the experiences of Michigan, Florida, and

[4] It is beyond the scope of this study to evaluate the appropriateness, use, and effectiveness of each legislative entity.

Missouri before deciding to merge their health care agencies.

In the four states where there are two agencies, the state contacts noted that there are separate cabinet level agencies. According to respondents, the agencies often collaborate particularly with respect to Medicaid policy and practice. The "welfare agency" has the responsibility for determining eligibility for services, and the "health agency" is responsible for meeting the health needs of the recipients. In most instances, the policies are designed at the state level and implemented at the local level. However, in one state, Ohio, the Medicaid agency is "pushing everything to the local level," because both planning and service delivery are becoming more "community oriented." In Ohio, it is likely that the health agency will soon follow suit.

2. What are the *major* issues faced by health planners in your state?

A pressing current issue in state health care planning is Medicaid. Medicaid reforms are influencing access to services, the availability of health care service to various segments of the population, and who pays, at what level, and over what period of time (see Table 10). The state contacts indicated that the service providers, particularly hospitals, are feeling the effects of Medicaid reform. Many hospitals are closing their doors, and "Mom and Pop" service providers -- small pharmacies and health providers -- cannot meet the demands of managed care. The state contacts believe new federal regulations have the potential to segment citizenry who are unable to access health care because of cost and service availability. In rural areas of the states studied, service providers are unable to stay in business; they simply lack the capacity to serve. Throughout the states surveyed, businesses, particularly the smaller ones, are unable, or choose not, to pay adequate insurance benefits. Although the impact reaches across the age spectrum, young children and the aged are those most often under-served or unserved. Several states are considering separate legislation that will enable the creation of children's health insurance to ensure that no child is without medical services. In these states, children who are eligible range in age from birth to age 18.

Several state contacts noted that one emerging problem is that low-income/economically disadvantaged citizens are choosing to spend their limited resources on food and shelter, rather than on medical care. They often wait until illness is advanced to come in for assistance. Although this often results in their becoming eligible for public assistance, their illnesses are so severe costs are higher and treatment lasts longer, causing a drain on providers.

The four states contacted also appear to be experiencing much difficulty in defining and measuring health quality, resulting in problems assessing and planning for the needs of their citizens. Furthermore, this leads to problems with accountability.

Because design and delivery are moving to the local level, state planners are finding it necessary to facilitate a change in the perceptions that citizens, professionals, and providers hold in the areas of service delivery and payment. It is precisely these images that drive and restrain the restructuring of the system.

A related issue concerns long-term care and the impact of managed care. The state contacts indicated that state and regional hospitals are closing in favor of community treatment options. State health monies are being distributed at the local level leading to a community desire to keep the resources local. According to one state contact, there has been a dependency on nursing homes for long-term care. The trend is toward more home health care options.

Finally, the state contacts indicated that the reforms in health care delivery and payment are affecting professional development schools. They must produce not only more "generalists," but they must also train people who are willing to focus more on community-level health needs and become part of an increasingly integrated system. The change in the payment for service and the point-of-service to the private sector also raises questions of funding for professional development schools. Many state contacts suggested that the proportion of public to private dollars expended to support preparation must be reversed.

3. What is the role played, if any, in the formation, implementation, and/or monitoring of health care policy by advisory boards and councils?

All states interviewed used boards and councils to form health care policy and to monitor and advise government on health care issues. Most of these were established through code, and most have no sunset provisions. Several were formed as a result of federal requirements, but many are established to give a particular constituency (e.g., persons with disabilities) a voice in government or to address a specific issue (e.g., transportation and housing). As in Virginia, the Governor and legislature of these states have attempted to reduce the number of the boards. However, even though they are narrowly defined, the boards and councils do represent an opportunity for citizen participation, as well as an opportunity for political patronage. Furthermore, relatively few resources are required to operate the boards, given the opportunity for public involvement. As such, the reductions have been minimal.

Most states reported that there were few regulatory or policy making boards, usually one per agency. The majority of the boards are advisory.

The state contacts indicated a need for boards and councils to collaborate to ensure a consistent approach to health planning that reflects the delivery of health services. Even if the numbers cannot be contained, the individual boards must be brought together so that a "big picture" of health needs of the state can be developed. In these ways, the individual needs can be viewed in relation to the totality of need.

4. What role, if any, does the federal government play in the formation of health policy?

The federal role is defined by those interviewed both in terms of money to support mandated services and in regulations for the design, delivery and monitoring of services. Most of the states did not see the federal influence as intrusive. In fact, two states viewed it as

positive. In Maryland, no doubt because of the close proximity to Washington, representatives of federal agencies often participate in public meetings as stakeholders as well as consultants. In Ohio, the federal role was viewed in a positive light by one interviewee who indicated that federal requirements caused the state to look at new service options and arrangements. All responded that the federal influence was important in the formation of boards. Although these requirements bring in contributions from professionals, citizens, and consumers, the downside is that they often result in very narrowly focused boards.

5. What are the key factors that influence successful health planning in your state?

The state contacts described several key factors necessary for successful health planning (see Table 11). By far, the most frequently mentioned factor was leadership across the executive and legislative branches of government. The agency leaders and key legislators must have a good grasp of the challenges faced by health care planners, providers, and payors. Leaders must have a solid understanding of the financial drivers and barriers. Some interviewees indicted that many appointed agency leaders did not have the experience to provide the necessary vision to set the course for health care planning. In these instances, it was important to involve senior level career executives.

Broad-based involvement was another essential ingredient. One state contact said that planners have to involve real people with real problems at the very beginning of the process so legislators and policy makers can "put a face on the problems."

Similarly, all interviewees emphasized the need for a public planning process. The planners must establish several vehicles for stakeholder input. Focus groups, surveys, and community forums were among the alternatives most frequently mentioned.

All interviewees indicated a need to have essential information available for planners. The availability of technically sound and believable data is crucial. Planners need evidence they can provide to support their requests. Data systems have to be comprehensive, reaching across the service spectrum and accessible by multiple audiences. One of the most important data elements is collection of utilization rates across services and programs that demonstrate trends and variability. Data systems have to be accessible to a variety of planners in both public and private settings. Finally, the information entered into data bases must be past, present, and future oriented to enable trend setting and forecasting.

Legislators are key players in the health planning process, and many need to be trained in the economics of health care. This is made more difficult because of the turnover at each election. Legislators must be involved from the beginning and need to be part of the planning from forming the vision and mission to developing the strategies to achieve the mission.

Industry leaders, both providers and payors, must also be involved in the planning. These individuals have a tremendous stake in the outcomes as well as the implementation, and final

success of the mission.

Finally, most interviewees saw a need for a comprehensive health planning group. Many supported having this group independent from state government. Georgia presented an exceptional model for such a group -- The Georgia Coalition for Health, Inc. This "nonprofit, nonpartisan organization was formed to develop public consensus on health care issues" in Georgia and makes recommendations to the appropriate health agencies, the Governor, and the legislature. The 32 member board is composed of citizens, professionals, educators, business and industry leaders, and legislators. According to one interviewee, the success of the Coalition is dependent on business and community. A key to success not only is the independence of the Coalition, but also the public process used to gather input.

VI. Concluding Remarks

The following goals provided direction for the study:

- Update the inventory resulting from a previous legislative study conducted by the Joint Commission on Health Care pursuant to SJR 104 of 1996 and make recommendations as to appropriate revision, consolidation, or elimination of the health care-related boards;

- Create a comprehensive inventory of all health policy-related entities that are composed of, or are appointed by, legislative members; and,

- Investigate and report on the ways in which Georgia, Maryland, North Carolina, and Ohio develop health care policy.

The study revealed a total of 79 boards throughout state, regional, and local government. The majority of these boards are meeting as planned and fulfilling their obligations as outlined in Code. Perhaps more important, these boards provide a significant opportunity for consumers, citizens, and professionals to take an active role in Virginia government. Further, the availability of the boards enables stakeholders who are not board members to present issues for consideration and to report the impact of health policy and practice on the community.

We have identified a number of boards that have not met in accordance with the expectations set forth in Code. Indeed, some have not even appointed members. Based on our interviews, reviews of the Code and other information, we have recommended that these boards be eliminated or restructured. However, the Secretary and members of the General Assembly may wish to study some of these recommendations further. The most important question to ask is "Does the reason for establishing this particular board still exist?" In the main, agency contacts were able to answer this question for those boards that have not met. Most indicated that the purpose either did not presently exist or could be addressed by another board or by

administrative action. However, removing these boards also takes away opportunities for citizen input into government decision making, one of the most important features of the board concept.

One of the most difficult decisions faced by the study team related to the Virginia Health Planning Board. As noted, this Board has not met for several years. The JCHC study pointed out this fact. There are several options that could be followed, but the intended purpose for the Board must be kept in mind. According to the Code, the purpose, in part, was to provide leadership for the health planning system. No one would question that this need persists today. All contacts, both within the state as well as those from target states, indicate that in this time of health care policy reform such leadership is essential. Furthermore, our information strongly suggests that the leadership must be informed by stakeholder advice. Therefore, we have concluded that if the decision is made to eliminate the Board, then another vehicle for ensuring leadership and citizen input on the health system needs must be in place. One potential alternative is to form a coalition similar to the Georgia Coalition for Health, Inc.

Another persistent theme sounded by the Assembly members and the Secretary is the importance of networking and collaboration among existing boards. Our analysis confirmed this need, but also confirmed the JCHC finding that if such interactions are present, they are informal at best. Through our search, we identified a number of legislative boards and study commissions that have a health focus. We have noted logical linkages between these and boards in the executive branch. Networking across the two branches is important for at least two reasons. Often, it was noted that the legislative commissions were set up to study specific health-related issues. Their findings could be important to executive boards obligated to identify similar issues and advise policy makers. Second, such linkages strengthen the opportunity for creating a system-wide perspective on the health needs of Virginians.

Further study is needed to understand how Virginia's boards address the critical issues facing the Commonwealth (see Appendix 10). The issues are varied, ranging from keeping individuals off welfare to encouraging the development of new and better antibiotics. To be the most appropriate and useful, the Commonwealth's boards should relate directly to one or more of the state's critical issues. By doing so, the Commonwealth will take another important step in its efforts to improve Virginia's health care system.

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH (DOH)							
1	Board of Health	§32.1-5	Provide leadership in health planning and policy development for the Commonwealth and Department of Health; implement a coordinated, prevention-oriented program that promotes and protects the health of all Virginians	11	Two from Medical Society of VA; One each from: VA Pharm. Assoc., VA Dental Assoc., VA Nurses Assoc., VA Vet. Med. Assoc., Local Gov., Hospital Industry, Nursing Homes, and Two Consumers	Governor	4/yr.	At least 4/yr.
2	State Emergency Medical Services Advisory Board	§32.1-111.10	Advise the Board of Health and review and make recommendations on the Statewide Emergency Medical Services Plan	24	One each: VA Municipal Leag[illegible] and VA Assoc. of Counties; Numerous Med./ Emerg./ Nursing Assoc.; 1 consumer; 8 reps of each of the Regional Councils	Governor	> 4/yr.	At least 6/yr.; twice to review grant requests, and at least 4 other meetings
3	Regional Emergency Medical Services Councils	§32.1-111.11	Receive and disburse public funds; develop and implement regional EMS delivery system	Varies among the 8 regional EMS Councils	Local government, fire protection, law-enforcement, EMS agencies, hospitals, physicians, emerg. nurses, mental health Prof., EMS techs, and other appropriate medical professionals	Board of Health designates Regional Councils	Varies among the 8 regional EMS councils	Varies among the 8 regional EMS councils
4	Financial Assistance and Review Committee	§32.1-111.12:01	Administer the Rescue Squad Assistance Fund, review grant applications, and make recommendations for funding	6	Representatives of regions encompassed by Regional EMS Councils	State EMS Advisory Board	6/yr.	6/yr.
5	Virginia Health Planning Board	§32.1-122.02	Supervises and provides leadership for the state health planning system; provides technical expertise in developing state health policy; makes recommendations on health policy, legislation, resource allocation, and statewide data collection for health care manpower distribution and for mortality and morbidity rates; and promulgates regulations as necessary	18	8 consumers; 4 providers; Comm. of Health; Comm. of DMHMRSAS; Dir. Dept. for Aging; Dir. of DMAS; Comm. of Social Services; and Sec. of Health and Human Resources (serves as Chairman)	Governor		No meetings for several years
6	Regional Health Planning Agencies/Boards	§32.1-122.05	Assist Health Planning Board: conduct data collection and research; prepare reports; conduct needs assessments; and identify gaps in services. The five Regional Health Planning Agencies/Boards are quasi-public because they were created by legislation, and are supported by public funds. However, they are organized as private, not-for-profit corporations.	99	Consumers, providers, a director of local health dept./dir. of social services dept., CSB, Area Agency on Aging, health care insurers, local govt., business rep., and academic community. Majority must be consumers	State Health Planning Board establishes procedures for appointments	Varies among the 5 regional boards from 4 12/yr.	Varies among the 5 regional boards.

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH (DOH) (continued)							
7	Home Care Services Advisory Committee	§32.1-162.14	Advise and make recommendations to Board of Health on implementation and administration of laws pertaining to home health services	10	4 reps. of home care orgs; 2 citizens; 1 each from: DSS, Dept. for Aging, DMAS, and DRS	Commissioner of Health		Has not met in 10 years.
8	Human Research Review Committees	§32.1-162.19	Ensure competent, complete and professional review of human research activities of institutions conducting human research	Not specified	Representatives of varied backgrounds	Each institution conducting human research	As needed	Inactive
9	Hemophilia Advisory Board	§32.1-89	Consult with the Board of Health in establishing and administering a program for care and treatment of persons with hemophilia and related diseases who are unable to pay entire cost of services despite existence of insurance	7	1 each: hospitals, medical schools, blood banks, vol. agencies interested in hemophilia, local public health agencies, medical specialists, and general public	Governor	Meets > 1/yr.	Met twice in 1995 and twice in 1997
10	State Health Dept. Sewage Handling and Disposal Appeal Review Board	§32.1-166.1	Hear all administrative appeals of denials of onsite sewage disposal system permits; make recommendations for alternative solutions in denial of permit	7	Persons with various backgrounds in soil analysis and sewage treatment	Governor (Governor's appointments subject to confirmation by the General Assembly)	Meets 8 times/yr	Meets 8/yr.
11	Virginia Voluntary Formulary Board	§32.1-80	Evaluate scientific data to determine which generic drugs are interchangeable with brand-name drugs; (approved products are included in formulary); make formulary available to providers of health care and others; and disseminate information to encourage appropriate use	12	4 physicians; 2 pharmacists; 1 biopharmaceutist; 1 dentist; Chair-man of Pharmacology at VCU; Adm. of Consumer Affairs of Dept. of Agriculture and Consumer Affairs; 1 member of public; and Attorney General (ex officio)	Governor	Quarterly, or upon call of 2 officers or Commissioner of Health	Meets at least quarterly
12	State Child Fatality Review Team	§32.1-283.1	Develop and implement procedures to ensure that child deaths in Virginia are analyzed in a systematic way; recommend prevention, education and training programs	16	Comm. DMHMRSAS; Director of Child Protective Services of DSS; Supt. Public Instruction; State Registrar of Vital Records; Dir. of Dept of Criminal Justice Services; and 1 each: local law enf., local fire depts., local depts. of social services, Medical Society of Virginia; College of Emergency Physicians, VA Pediatric Society, VA SIDS Alliance, local emerg. medicine personnel, Commonwealth's Attorneys, and CSBs; Chief Medical Examiner is Chairman	Governor	6/yr. and additional meetings as needed	Likely to meet 8 or 9 times in 1997

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH (DOH) (continued)							
13	AIDS Advisory Board	§32.1-11.1	Assist in development of the criteria for awarding AIDS education grants	No longer applicable	Experts in the delivery of services to persons with AIDS and AIDS education	Board of Health	As needed	Has not met in the past few years.
14	HIV Community Planning Committee	Fulfills the Department of Health's HIV Prevention Cooperative Agreement with the CDC	Assess present and future distribution and impact of HIV/AIDS; assess the community's capability to respond through existing HIV prevention resources; identify unmet HIV prevention needs; and develop a Comprehensive HIV Prevention Plan.	31	Committee is composed of persons with educational, work-related and/or personal experience with HIV/AIDS; membership represents diverse backgrounds with respect to gender, race, sexual orientation, and geographical region.	Commissioner of Health	Every 6 weeks	Every 6 weeks or more
15	AIDS Drug Assistance Program	Required to receive Federal funding under Ryan White CARE Act and ADAP formulary	Advises the Department of Health on enrollment criteria, medication utilization, and additions or deletions to the formulary for the AIDS drug assistance program. Works with distribution of AZT and ZDV and other drugs.	16	7 physicians; 1 nurse practitioner; 1 pharmacist; 1 Ryan White consortia representative; 1 medical ethicist; 4 individuals with HIV infection	Division of STD/AIDS	4/yr.	Meets 4/yr.
16	Nursing Scholarships Advisory Committee	§23-35.9	Awards nursing scholarships for undergraduate and graduate nursing students in conjunction with the Board of Health	8	4 deans or directors of schools of nursing; 2 past nursing scholarship recipients; and 2 persons w/ exp. in administration of student financial aid programs	Board of Health	1 - 2/yr.	Meets 1-2/yr.

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH (DOH) (continued)							
17	Virginia Transplant Council	§32.1-297.1	Conduct educational and informational activities as they relate to organ and tissue procurement and transplantation	18	1 each from 18 Organizations: Bone Marrow Transplant Progs MCV Hospitals, VA Blood Services, UVA Medical Center; Carolina Procurement Agency; INOVA Fairfax Hospital; Henrico DR's Hospital; Lifenet; Life Resources Reg Donor Center; Lion's Medical Eye Bank; Roanoke Mem. Hosps; Sentara Norfolk General Hospital; South-Eastern Organ Procurement Fdn; UVA Health Sciences Center; VA Hospital and Healthcare Assoc; VA's Organ Procurement Agency, Washington Reg Transplant Consortium	Each of the 18 participating organizations appoints a member	4/yr.	4/yr.
18	Commonwealth Neurotrauma Initiative Advisory Board	§2.1-1.6 and §32.1-73.1 through §32.1-§73.4	Prevent traumatic spinal cord or brain injuries and improve treatment and care of Virginians with these conditions. Moneys in the fund used to support grants for VA based organizations for education on prevention, research and treatment of neurotrauma.	7	1 licensed practitioner with brain or spinal cord experience; 1 practitioner licensed by health regulatory board with brain or spinal cord injury rehabilitative program or services experience; 1 with a traumatic spinal cord injury or caretaker thereof; 1 with brain injury or caretaker thereof; 1 citizen-at-large; the State Health Comm. and the Comm. of Rehabilitative Serv. or their designees. (The initial members of this Board, which was created by the 1997 General Assembly, have not yet been appointed	Governor	Has just recently been established	Not yet applicable
19	Radiation Advisory Board	§32.1-233	Review and evaluate policies and programs of Virginia relating to ionizing radiation; make recommendations to SHC, SBH, dir. of DEQ; furnish tech. advice on matters relating to development, utilization, and regulation of sources of ionizing radiation	10	Reps from industry, labor, agriculture; individ. with scientific training in radiology, medicine, radiation or health physics or related sciences. 7 ex-officio members including State Health Commissioner (Chair).	Governor	1/yr.	1/yr.

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH PROFESSIONS							
20	Board of Health Professions	§54.1-2507	Evaluate need for coordination among health regulatory boards; consider whether health professions or occupations should be regulated and degree of regulation to be imposed; provide means of citizen input to Dept.; advise Governor and General Assembly on health professions' regulation; review/comment on regulation; and review various processes of the Department of Health Professions	17	1 rep. from each of the 12 Reg. Boards; 5 from Commonwealth at large	Governor (Governor's appointments subject to confirmation by the General Assembly)	At least quarterly	4 meetings in FY 97 and 25 additional committee meetings
21	Board of Audiology and Speech Pathology	§54.1-2602	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	7	2 audiologists; 2 speech pathologists; 1 otolaryngologist; 2 citizens	Governor	As needed	4 meetings in FY97, and 4 committee meetings
22	Board of Dentistry	§54.1-2702	Evaluates qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations, and take disciplinary actions	10	7 dentists, 1 citizen, and 2 dental hygienists.	Governor	As needed	3 meetings in FY97, and 20 committee meetings
23	Board of Funeral Directors and Embalmers	§54.1-2802	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; take disciplinary actions; regulate pre-need funeral contracts; establish standards for schools of mortuary science	9	7 funeral service licensees, 2 citizens	Governor	2/yr.	4 meetings in FY97, and 12 committee meetings
24	Board of Medicine	§54.1-2911	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	17	1 medical physician from each congressional district; 1 osteopathic physician; 1 podiatrist; 1 chiropractor; 1 clinical psychologist; and 2 citizens	Governor	As needed	3 meetings in FY97, and 53 committee meetings
25	Psychiatric Advisory Board	§54.1-2924	Examine persons licensed or seeking licensure, and advise Board of Medicine on mental or emotional condition of such persons when such condition is in issue before the Board of Medicine	Not specified	Licensed practitioners	Board of Medicine	As needed	Has not met for several years.
26	Advisory Board on Physical Therapy	§54.1 - 2944	Assist the Board of Medicine carry out provisions of law regarding physical therapists	5	5 physical therapists with not less than three years of practice	Governor	As needed	3 meetings in FY97
27	Advisory Board on Respiratory Therapy	§54.1-2956	Assist the Board of Medicine carry out provisions of law regarding respiratory therapists	5	3 respiratory therapists; 1 physician; and 1 citizen at large	Governor	As needed	3 meetings in FY97

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH PROFESSIONS (continued)							
28	Advisory Board on Occupational Therapy	§54.1-2956.2	Assist the Board of Medicine carry out provisions of law regarding occupational therapists	5	3 occupational therapists; 1 physician; and 1 citizen at large	Governor	As needed	3 meetings in FY97
29	Advisory Committee on Radiological Technology	§54.1-2956.8	Assist the Board of Medicine carry out provisions of law regarding radiological technology practitioners	6	4 radiology technology practitioners; 1 radiologist; 1 member of Board of Medicine	Board of Medicine	As needed	2 meetings in FY97
30	Advisory Committee on Acupuncture	§54.1-2956.11	Assist the Board of Medicine carry out provisions of law regarding acupuncturists	7	3 physicians who practice acupuncture; 3 licensed acupuncturists; 1 member of Board of Medicine	Board of Medicine	As needed	2 meetings in FY97
31	Board of Nursing	§54.1-3002	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; take disciplinary actions; perform other related functions	13	7 RNs; 3 LPNs; 3 citizens at large	Governor	Annual	6 meetings in FY97, and 76 committee meetings
32	Board of Optometry	§54.1-3207	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; take disciplinary actions; perform other related functions	6	5 optometrists; 1 citizen at large	Governor	As needed	5 meetings in FY97, and 25 committee meetings
33	Board of Pharmacy	§54.1-3305	Regulate the practice of pharmacy and the manufacturing, dispensing, selling, distributing, processing, compounding, or disposal of drugs, cosmetics and devices	10	8 pharmacists; 2 citizens at large	Governor	Annual	6 meetings in FY97, and 14 committee meetings
34	Intervention Program Committee	§54.1-2517	Examine eligibility of licensed health care providers to participate in the health practitioners' intervention programs	7	1 physician and 6 other licensed health care providers	Director of the Department of Health Professions	This is a new committee	
35	Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals	§54.1-3503	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; take disciplinary actions; perform other related functions	14	8 professional counselors; 2 citizens at large; 2 marriage and family therapists; 2 substance abuse professionals	Governor	As needed	4 meetings in FY97, and 27 committee meetings
36	Board of Psychology	§54.1-3603	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	9	7 psychologists; 2 citizens at large	Governor	As needed	7 meetings in FY97, and 35 committee meetings

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF HEALTH PROFESSIONS (continued)							
37	Advisory Committee on Certified Practices	§54.1-3609 Expires on July 1, 1999	Recommend to appropriate Boards standards for voluntary certification of their licensees; recommend standards for mandatory certification of sex offender treatment providers otherwise exempt from licensure	10	1 each from the Boards of: Medicine, Nursing, Professional Counselors, Psychology, Social Work; 2 citizens from Board of Health Professions or other Boards; 3 sex offender treatment providers	Boards of Medicine, Nursing, Prof. Counselors, Psychology, Social Work, Health Professions	As needed	Did not meet in FY97
38	Advisory Board on Rehabilitation Providers	§54.1-3510	Recommend to the appropriate Boards standards for certification of rehabilitation providers	10	1 each from the Boards of: Medicine, Nursing, Professional Counselors, Psychology, Social Work; 2 citizens from Board of Health Professions or other Boards; 3 treatment providers	Boards of Medicine, Nursing, Prof. Counselors, Psychology, Social Work, Health Professions	As needed	4 meetings in FY97
39	Board of Social Work	§54.1-3703	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	7	5 social workers; 2 citizens at large	Governor	As needed	5 meetings in FY97, and 11 committee meetings
40	Board of Veterinary Medicine	§54.1-3802	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	7	5 veterinarians; 1 veterinarian technician; 1 citizen at large	Governor	Annual	6 meetings in FY97, and 35 committee meetings

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)							
41	Board of Medical Assistance Services (BMAS)	§32.1-324	Prepare, amend and submit to the Federal Government a state plan for medical assistance services (Medicaid); promulgate regulations; provide policy oversight for Medicaid program	11	5 health care providers; 6 who are not providers	Governor	As Needed	5 meetings in FY97
42	Advisory Committee on Medicare and Medicaid	§32.1-328	Advise Governor on responsibilities of Commonwealth re: Medicare and Medicaid programs	21	Reps. of providers receiving 3rd party payments from Medicare and Medicaid; reps. of other 3rd party payors, consumer groups and recipients; Comms. of DOH, DMHMRSAS, DSS and Dir. of DMAS are ex-officio	Governor	As Needed	Has not met since June 1991; all appointments have expired
43	Medicaid Prior Authorization Advisory Committee	§32.1-331.13	Make recommendations to BMAS regarding drugs to be subject to prior authorization	11	5 physicians; 4 pharmacists; 1 mental health consumer; and 1 Medicaid recipient	Board of Medical Assistance Services	As needed	Inactive
44	Indigent Health Care Trust Fund Technical Advisory Panel	§32.1-335	Recommend to BMAS policy and procedure for administering the fund; currently working on pilot project to convert fund to insurance product for working uninsured	15	Chairman of BMAS; Dir. of DMAS; Comms. of Health and Bureau of Ins. (or designee); Chairman of Va. Health Care Foundation (or designee); 2 BMAS members; 2 hospital CEOs; 3 reps. of private enterprise; 2 reps. of insurance ind.; and 1 physician	Board of Medical Assistance Services	As needed	Last meeting took place in the fall of 1996
45	Medicaid Pharmacy Liaison Committee	Chap. 912, Item 322 D 1996	Investigate implementation of quality cost-effective health care initiatives such as prospective drug utilization review, disease state management, and pro-DUR in the long-term care community	5	3 registered pharmacists, 1 rep from Pharmaceutical Research & Manufacturers of America, and 1 Registered Pharmacist from the VA Pharmacists Assoc.	Dept. of Medical Assistance Services	As needed	

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES (DMHMRSAS)							
46	State Mental Health, Mental Retardation and Substance Abuse Services Board	§37.1-3	Develop and establish policies on state hospitals and CSBs; develop long-range plans for MHMRSAS; advise Governor and General Assembly on MHMRSAS issues; and promulgate rules and regulations	9	> 1/3 shall be consumers of MHMRSAS services or family members of consumers	Governor (Governor's appointments subject to confirmation by the General Assembly)	At least 4/yr.	4/yr.
47	Alzheimer's Disease and Related Disorders Commission	§37.1-62.1	Advise Sec. of HHR and develop a plan for funding local initiatives for services to victims of Alzheimer's disease and related disorders	14	6 members of Alzheimer's Disease and Related Disorders Assoc.; 8 health professionals. Members were not reappointed by the current Administration.	Governor		Has not met over the past 4 years.
48	Governor's Council on Alcohol and Drug Abuse Problems	§37.1-207	Advise and make recommendations to the Governor on broad policies, goals and coordination of public & private efforts to control alcohol & drug abuse	19	1 rep. from: Sec. of HHR, Sec. of Transp., Sec. of Public Safety; 5 reps. of state agencies w/ resp. in substance abuse; 2 local govt. agencies w/ resp. for substance abuse; and 9 general public	Governor		Has not met over the past 4 years.
	DEPARTMENT OF REHABILITATIVE SERVICES (DRS)							
49	Board of Rehabilitative Services	§51.5-4	Provide access to Dept. of Rehab Services; publicize policies/programs of Dept. to educate public; monitor activities of Dept.; advise on regulations of Dept.; and advise Governor, Sec. of HHR and General Assembly on delivery of services	9	Must include a representative of local government; several persons with disabilities	Governor (Governor's appointments subject to confirmation by the General Assembly)	4/yr.	4/yr.
50	Statewide Rehabilitation Advisory Council	§51.5-9.01	Provide advice to the Dept. of Rehab Services regarding vocational services provided pursuant to Federal Rehabilitation Act	22	Based on Federal provisions; majority are persons with disabilities	Governor	4/yr.	4/yr.
51	Statewide Independent Living Council	§51.5-25.1	Assist DRS carry out activities required under Title VII of the Federal Rehabilitation Act; and advise DRS on these matters	14	Based on Federal provisions	Governor	4/yr.	4/yr.
52	Disability Services Council	§51.5-49	Develop guidelines for local disability services boards; develop grant application system; and provide final review of grant awards	8	Comms. of DRS, and Dept. for Vis. Handicapped; Dir. of Dept. for Deaf & Hard-of-Hearing; Supt. of Public. Instruct.; 3 consumers; and 1 local government rep	Governor	As needed; generally 2 3/yr.	Met approximately 3 times in FY97

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF REHABILITATIVE SERVICES (DRS) (continued)							
53	Virginia Council on Assistive Technology	Not applicable; Council was initiated in 1992	To assist in the development of a statewide assistive technology system; to provide related advice and guidance to the Dept of Rehabilitative Services and to the Virginia Assistive Technology System	18	15 are persons with disabilities, or family members. Reps from the various State agencies which work with people with disabilities also sit on this Council	Nominating Committee makes recommendations to the Council. Nominees must be confirmed by DRS	4/yr.	4/yr.
	DEPARTMENT OF PERSONNEL AND TRAINING							
54	Local Health Benefits Advisory Committee	§2.1-20.1:02	Advise DPT on administration of local health benefits programs	7	Local govt, teachers, school officers, school board members, retirees	Governor	Meets 2-3/yr.	Met 2 times in FY97
55	State Health Benefits Advisory Council	§2.1-20.1:01	Advise Sec. of Administration on issues/concerns regarding the state employees' health benefits program	17	2 retirees (former state employees); 11 employees (8 or 9 from other state agencies); 4 citizens	Governor appts 9, House: 4, Senate: 4 (Governor's appointments subject to confirmation by the	Meets 2-3/yr. Meetings are called by the Secretary of the Admin.	Met 2 times in FY97
	SECRETARY OF HEALTH AND HUMAN RESOURCES							
56	Maternal and Child Health Council	§9-317	Improve the health of the Commonwealth's mothers and children by promoting and improving programs and service delivery systems related to maternal and child health	11 appointed members; 5 ex-officio members	5 health professionals; 2 rep. of private/non-profit org.; 1 rep. of private industry; 1 rep. of religious community; 1 local public official; and 1 rep. of hospital. Ex-officio members (Director of DMAS, Comms. of DOH, DSS, DMHMRSAS and Supt. of Public Instruction) Secretary of HHR is Chairman	Governor	4/yr.	4/yr.
57	VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES	§51.5-31	Advise Sec. of HHR and Governor on issues and problems of interest to persons with disabilities; submit needs assessments; serve as State Planning Council for administration of certain federal laws; appoint and supervise Director of Board; hire staff.	40	Reps. of nine state agencies, including DMH, DRS, DRVD; reps. of numerous organizations and interests; persons w/ developmental disabilities; persons w/ mentally impairing dev. disabilities; and relatives or guardians of persons w/ disabilities.	Governor	At least quarterly	At least quarterly

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT FOR THE RIGHTS OF VIRGINIANS WITH DISABILITIES (DRVD)							
58	Protection and Advocacy for Individuals with Mental Illness Council	Dept. Bylaws	Advise the Department for the Rights of Virginians with Disabilities regarding advocacy issues for disabled Virginians	20	9 consumers; 2 family members of persons with disabilities; 5 mental health professionals; 1 attorney; 1 member of the public knowledgeable about mental illness. Membership reflects regional representation.	DRVD Director	4/yr. and as needed	6 meetings in FY97
	DEPARTMENT FOR THE VISUALLY HANDICAPPED							
59	Virginia Board for the Visually Handicapped	§63.1-68	Advise Governor, Sec. of HHR and General Assembly on delivery of public services to and the protection of rights of persons with visual disabilities	7	4 must be persons who are blind	Governor	4/yr.	4/yr.
60	Statewide Rehabilitation Advisory Council for the Blind	§63.1-70.1	Provide advice to Dept. for Visually Handicapped regarding vocational services provided pursuant to Title I and VI of the Federal Rehabilitation Act	16	1 rep from each, Parent Training and Info Cntr, Client Asst Prog, Voc Rehab Counselor (ex-officio), Comm Rehab Prog, Independent Living Council; 2 reps from Disability Advocacy Gps; 4 reps of business, industry and labor; 5 recipients of voc rehab services	Based on Federal provisions	4/yr.	4/yr.
61	Joint Advisory Board for the Industries for the Blind	§63.1-73b	Advise the Virginia Board for the Visually Handicapped on each of the Workshops of the Industries for the Blind. Advise the managers of Workshops on business trends, contract opportunities; review fiscal and budgetary matters that relate to the Workshops	9	At least 2 persons who are blind, or parents of blind; at least 2 representatives of Human Service Agencies; the remainder are local business people from manufacturing entities, and other employers	First Board members appointed by VA Bd for Visually Handicapped; when those terms expire this Board determines new appointments	4/yr.	4/yr.

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT FOR THE DEAF AND HARD-OF-HEARING							
62	Advisory Board for the Department for the Deaf and Hard-of-Hearing	§63.1-85.1:1	Ensure development of long-range programs for hearing-impaired Virginians; advise Governor, Sec. of HHR, Dir. of Dept, and General Assembly on matters involving the hearing impaired	9	4 reps. of deafness-oriented professions; 4 citizens who are hearing-impaired; 1 parent of a hearing-impaired child	Governor	4/yr.	4/yr.
	INTERAGENCY							
63	State Executive Council for At Risk Youth & Families	§2.1-746	Provide for establishment of interagency programmatic and fiscal policies which support services for at-risk youth and families; oversee administration of state interagency policies governing use and distribution of state funds; and advise Governor on relevant issues	7	Comms. of DMHMRSAS, DOH, and DSS; Supt. of Public Instruction; Ex. Sec. of Va. Supreme Court; Dir. of Dept. of Youth and Family Services; and 1 parent representative	Governor	12/yr.	12/yr., Meets once per month, the CSA Director calls the meetings at the instruction of the Chairman
64	Virginia Council on Coordinating Prevention	§9-268	Develop programs which: promote the maximum independence of individuals and strengthen families; avoid or minimize physical or mental disability or dysfunction; and encourage future cost savings through early intervention or treatment	18	1 each from: Advisory Board for Aging, Va. Council on Child Day Care and Early Childhood Programs, Board of Corr. Ed., State Bd. of Corr., State Bd. of Youth Serv., Crim. Jus. Serv. Bd., State Bd. of Ed., State Bd. of Health, Board of Med. Asst. Services, Council on Status of Women, State MHMRSAS Board, VA Board for People with Disabilities, and the Board of Social Services; and 5 citizens at large	Governor		Has not met for approximately 7 years
65	Interagency Coordinating Council on Housing for the Disabled	§2.1-703.1	Provide and promote cross-secretariat interagency leadership for comprehensive planning and implementation to maximize low-income housing for the disabled	10	1 rep. from numerous state agencies; Secs. of Commerce and Trade and HHR are ex-officio members	Executive of each agency represented on Council	Unknown	This Council has not met for approximately 3 years.
66	Interagency Migrant Worker Policy Committee	Est. in 1986 by Exec. Order Became a standing committee in 1997	Reviews, coordinates, evaluates and addresses issues regarding the approximately 14,000 migrant and seasonal farmworkers who help tend Virginia's crops each year	17	Each Committee member is a representative of a State Agency	Designated by the Agencies represented	Monthly	Monthly

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF SOCIAL SERVICES (DSS)							
67	Board of Social Services	§63.1-14	Advise the Governor on issues relating to social services	9	1 member from each of the welfare regions of the State established by the Commissioner of Social Services	Governor	6/yr.	6/yr.
68	Advisory Board on Child Abuse and Neglect	§63.1-248.16	Advise DSS and Board of Social Services on prevention and treatment of abused and neglected children and their families	16	9 persons with staggered terms and the following permanent members: Comms. of DOH and DMHMRSAS; Supt. of Public Instruction; Dir. of the Depts of Corrections; Youth and Family Services; Criminal Justice Services; and Attorney General or their designees	Governor	Quarterly	Quarterly
	DEPARTMENT FOR THE AGING (DA)							
69	Advisory Board for Department for the Aging	§2.1-373	Assist Dept. for the Aging in the performance of its duties	23	Membership appointments focus on: geographic representation, experience and interest in the field of aging. The majority of Board members are over the age of 60	Governor	4/yr.	4/yr.
70	Specialized Transportation Council	§9-320	Support the development of safe, cost-effective, coordinated and specialized transportation services for the elderly and disabled	10	Sec. of HHR is Chair; Sec. of Transp. is Vice Chair; 8 appointed members: 1 rep. of: large urban pub. transp. provider, small urban pub. transp. provider, a rural transp. provider; 3 consumers; and two at large members	Governor	Quarterly	Did not meet during the past year. During the 3 previous years, met approximately 4 times.
71	Specialized Transportation Technical Advisory Committee	§9-323	Assists the Specialized Transportation Council	12	Reps. from numerous state agencies; 3 reps. of public transportation providers or transportation district commissions	Specialized Trans. Council appoints 3 transp. reps.; appointing authority for others is not specified		Has not met for approximately 3 years.

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF EDUCATION (DOE)							
72	School Health Advisory Boards	§22.1-275.1	Assist the development of health policy in the school division and the evaluation of the state of school health, health education, the school environment and health services	<20	Parents, students, health professionals, educators, and others	Each School Board	>2/yr.	Schedules vary, but many meet a minimum of 4/yr.
	DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION							
73	Board for Opticians	§54.1-1703	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	5	3 opticians; 1 ophthalmologist; and 1 citizen at large	Governor	3/yr.	Meets at least 3 times per year
74	Board for Hearing Aid Specialists	§54.1-1502	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	7	4 licensed hearing aid specialists (one of which must also be a licensed audiologist), 1 otolaryngologist, and 2 citizens	Governor	3/yr.	Meets at least 3 times per year
	BUREAU OF INSURANCE							
75	Special Advisory Commission on Mandated Health Insurance Benefits	§9-297	Advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and providers	14	1 each: physician, hospital CEO, allied health prof., small business, major industry, and medical ethics expert; 2 health insurance reps., 2 citizens at large; 1 member of Senate Comm. on Ed. and Health; 1 member of Senate Comm on Labor; 1 member of House CIB Committee; Commissioners of Health and Bureau of Insurance are ex-officio members	Governor: 10 Sen. Privileges and Elections: 2 Speaker of House: 2	As needed and at the request of the Governor	3 meetings in FY97
	DEPARTMENT OF LABOR AND INDUSTRY							
76	Safety and Health Codes Board	§40.1-22	Study and investigate all phases of safety and health in business establishments; adopt, amend and repeal rules and regulations to further the safety and health of employees	14	Individuals from various industries who provide a mix of employer and employee representatives, as well as members of the general public	Governor	2/yr. or more depending on the number of Federal regulations issued by OSHA	At least twice a year. Met 2 times in FY97
77	Migrant and Seasonal Farmworkers' Board	§9-149 to 9-152	Addresses issues of importance to migrant and seasonal farmworkers, including housing, health care, employment, immigration, workers' compensation, transportation	15	Individuals from various parts of the State, who are involved with, or have an interest in, issues regarding seasonal and migrant farmworkers	Governor	Quarterly	Quarterly

Table 1. Inventory of Health Care-Related Boards, Commissions, Committees and Councils in the Commonwealth of Virginia (continued)

#	ENTITY	CODE AUTHORITY	MISSION/PURPOSE	NUMBER OF MEMBERS	MEMBER COMPOSITION	APPOINTING AUTHORITY	MEETINGS	
							REQUIRED MEETINGS	RECENT MEETING SCHEDULE
	DEPARTMENT OF MOTOR VEHICLES							
78	Medical Advisory Board for the Department of Motor Vehicles	§46.2-204	Advise Comm. of DMV through the development of medical and health standards to avoid the issuance of licenses to persons suffering from physical or mental disabilities or disease that will prevent their exercising reasonable control over a motor vehicle	7	All must be licensed physicians currently practicing medicine in Virginia	Governor	4/yr.	4/yr.
79	VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM	§38.2-5016	Administer the program and the fund	7	3 citizens; 1 participating hospital rep.; 1 participating physician rep.; 1 rep. of liability insurers; and 1 non-participating physician	Governor	12/yr.	Met 10 times in FY97

Table 2. Sixteen Health Care-Related Boards Added to the Original Joint Commission on Health Care Inventory

# as shown in Table 1	Added Board
	DEPARTMENT OF HEALTH
18	Commonwealth Neurotrauma Initiative Advisory Board
19	Radiation Advisory Board
	DEPARTMENT OF HEALTH PROFESSIONS
22	Board of Dentistry
34	Intervention Program Committee
	DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
45	Medicaid Pharmacy Liaison Committee
	DEPARTMENT OF REHABILITATIVE SERVICES
53	Virginia Council on Assistive Technology
	DEPARTMENT FOR THE RIGHTS OF VIRGINIANS WITH DISABILITIES
58	Protection and Advocacy for Individuals with Mental Illness Council
	DEPARTMENT FOR THE VISUALLY HANDICAPPED
60	Statewide Rehabilitation Advisory Council for the Blind
61	Joint Advisory Board for the Industries for the Blind
	INTERAGENCY
66	Interagency Migrant Worker Policy Committee
	DEPARTMENT OF SOCIAL SERVICES
67	Board of Social Services
	DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
74	Board for Hearing Aid Specialists
	DEPARTMENT OF LABOR AND INDUSTRY
76	Safety and Health Codes Board
77	Migrant and Seasonal Farmworkers' Board
	DEPARTMENT OF MOTOR VEHICLES
78	Medical Advisory Board for the Department of Motor Vehicles

Table 3. Summary Membership Profile of Health Care Boards

Categories	Number of Board Members*	Percentage of Total Board Members*
Consumers**	158	22%
Citizens**	49	7%
Professionals	337	47%
Inter-Agency Representation	85	12%
Intra-Agency Representation	8	1%
Regional	82	11%
Total	719	100%

* Individuals may serve on more than one board. Without knowing the actual names and affiliations of board members, we cannot determine how many separate individuals serve on all of Virginia's health care boards.

** The distinction between consumers and citizens appears in the "Member Composition" column of Table 1. Consumers are those who have some interest in the mission of a particular board, and/or may be recipients of the services overseen by that board. Citizens are individuals who have no evident direct connection to the work or mission of the board on which they serve.

Table 4.
Number of Boards with Various Membership Categories

Categories*	Number
Professionals and Consumers	16
Professionals and Citizens	21
Professionals Only	18
Consumers Only	2
Consumers and Citizens Only	1
Regional Only	5

* The distinction between consumers and citizens appears in the "Member Composition" column of Table 1. Consumers are those who have some interest in the mission of a particular board, and/or may be recipients of the services overseen by that board. Citizens are individuals who have no evident direct connection to the work or mission of the board on which they serve.

Table 5. Boards, by Agency Affiliation, Recommended for No Action

Department of Health

Board of Health
State Emergency Medical Services Advisory Board
Financial Assistance and Review Committee
Human Research Review Committees
Hemophilia Advisory Board
Sewage Handling and Disposal Appeal Review Board
Virginia Voluntary Formulary Board
State Child Fatality Review Team
HIV Community Planning Committee
AIDS Drug Assistance Program
Nursing Scholarships Advisory Committee
Virginia Transplant Council
Commonwealth Neurotrauma Initiative Advisory Board
Radiation Advisory Board

Department of Health Professions

Board of Health Professions
Board of Audiology and Speech Pathology
Board of Dentistry
Board of Funeral Directors and Embalmers
Board of Medicine
Advisory Board on Physical Therapy
Advisory Board on Respiratory Therapy
Advisory Board on Occupational Technology
Advisory Committee on Radiological Technology
Advisory Committee on Acupuncture
Board of Nursing
Board of Optometry
Board of Pharmacy
Intervention Program Committee
Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals
Board of Psychology
Advisory Committee on Certified Practices
Advisory Board on Rehabilitation Providers
Board of Social Work
Board of Veterinary Medicine

Table 5. Boards, by Agency Affiliation, Recommended for No Action (continued)

Department of Medical Assistance Services
- Board of Medical Assistance Services
- Indigent Health Care Trust Fund Technical Advisory Panel
- Medicaid Pharmacy Liaison Committee

Department of Mental Health, Mental Retardation, and Substance Abuse Services
- State Mental Health, Mental Retardation and Substance Abuse Services Board

Department of Rehabilitative Services
- Board of Rehabilitative Services
- Statewide Rehabilitation Advisory Council
- Statewide Independent Living Council
- Disability Services Council
- Virginia Council on Assistive Technology

Department of Personnel and Training
- Local Health Benefits Advisory Committee
- State Health Benefits Advisory Council

Secretary of Health and Human Resources
- Maternal and Child Health Council

Department for the Rights of Virginians with Disabilities
- Protection and Advocacy for Individuals with Mental Illness Council

Department of Visually Handicapped
- Virginia Board for the Visually Handicapped
- Statewide Rehabilitation Advisory Council for the Blind
- Joint Advisory Board for the Industries for the Blind

Department for the Deaf and Hard-of-Hearing
- Advisory Board for the Department for the Deaf and Hard-of-Hearing

Interagency
- Interagency Migrant Worker Policy Committee

Table 5. Boards, by Agency Affiliation, Recommended for No Action (continued)

Department of Social Services
- Board of Social Services
- Advisory Board on Child Abuse and Neglect

Department for the Aging
- Advisory Board for the Department for the Aging

Department of Education
- School Health Advisory Boards

Bureau of Insurance
- Special Advisory Commission on Mandated Health Insurance Benefits

Department of Labor and Industry
- Safety and Health Codes Board
- Migrant and Seasonal Farmworkers' Board

Department of Motor Vehicles
- Medical Advisory Board for the Department of Motor Vehicles

Virginia Board for People with Disabilities

Virginia Birth-Related Neurological Injury Compensation Program

Table 6. Boards, by Agency Affiliation, Recommended for Elimination

Department of Health

Home Care Services Advisory Committee
AIDS Advisory Board

Department for the Aging

Specialized Transportation Council
Specialized Transportation Technical Advisory Committee

Department of Medical Assistance Services

Advisory Committee on Medicare and Medicaid

Interagency

Interagency Coordinating Council on Housing for the Disabled

Table 7. Boards, by Agency Affiliation, Recommended for Further Study

Department of Health

Virginia Health Planning Board
Regional Emergency Medical Services Councils
Regional Health Planning Agencies/Boards

Department of Health Professions

Psychiatric Advisory Board

Department of Mental Health, Mental Retardation, and Substance Abuse Services

Governor's Council on Alcohol and Drug Abuse Problems
Alzheimer's Disease and Related Disorders Commission

Department of Medical Assistance Services

Medicaid Prior Authorization Advisory Committee

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
1	Senate Committee on Education and Health	Committee		Consider matters concerning education; persons under disability; public buildings; public health; mental health; mental retardation and health professions.		15 Members Appointed by P&E.	
2	House Committee on Health, Welfare and Institutions	Committee		Inquire into the condition and administration of the laws relating to the subjects of health, welfare, and institutions; investigate the conduct and look to the responsibility of public officers and agents concerned with those subjects; and to suggest such measures as will correct abuses, protect the public interests, and promote the public welfare.		22 Members Appointed by the Speaker	
3	Joint Commission on Health Care	Commission	9-311	Study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services.	Depts. of Health, Health Professions and DMAS	16 members: 7 Sen. appted by P&E; 9 Del. appted by Speaker, 3 of whom must be from HWI	Established 1992

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
4	Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute & Cancer Pain Management	Subcommittee to House and Senate Committees et al	SJR 72 (1994) HJR 583 (1995) HJR 256 (1996) HJR 565 (1997)	Examine current chronic, acute & cancer pain management efforts; the effectiveness of pain management provided by the Commonwealth's medical schools, health care providers, and chronic, acute and cancer pain management clinics; Virginia's current laws and public policy related to chronic, acute and cancer pain management; the pain treatment needs of chronic, acute and cancer patients; the special pain management needs of infants, children and adolescents; and the impact of inadequate pain management on resource utilization and costs. Determine state-wide needs related to inadequate chronic, acute and cancer pain management and any appropriate corrective actions, any law and public policy revisions needed to facilitate utilization of effective chronic, acute and cancer pain management; and the potential cost avoidance through aggressive chronic, acute and cancer pain management.	Dept. Of Health	11 members; 3 Sen. appted by P&E, 4 Del. appted by the Speaker, 4 citizens appted by the Gov. of whom 2 must be physician experts in pain management and 2 must be patients or relatives of patients with experience with pain management.	Established 1994; Continued 1995, 1996, 1997. To submit findings and recommendations to the Gov. and the 1998 session of the General Assembly
5	State Health Benefits Advisory Council	Council	§2.1-20.1:01	Advise Sec. of Administration on issues/concerns regarding the state employees' health benefits program.	DPT	17 members: 2 retirees; 11 employees; 4 citizens; Governor appts 9, Speaker appts 4 and P&E appts 4	

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
6	Joint Subcommittee to Study the Abatement of Lead-Based Paint in Virginia	Subcommittee to House and Senate Committees	SJR 245 (1993) SJR 127 (1994) SJR 287 (1995) SJR 70 (1996) SJR 227 (1997)	Study the abatement of lead-based paint. Examine policy and planning issues related to such abatement	Depts. Of Health, Professional & Occupational Regulation, Labor & Industry, Housing & Community Development	9 members; 1 owner of rental property and 1 contractor currently engaged in lead-based paint abatement appted by the Gov., 1 Sen. appted by P&E, 2 Del. appted by the Speaker. State Health Comm., Dir. of Dept. of Professional & Occupational Reg., Comm. of Labor & Industry, Dir. of Housing & Community Development as ex-officio members.	Established 1993; Continued 1994, 1995, 1996, 1997. To submit findings and recommendations to the Gov. and the 1998 session of the General Assembly

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
7	Commission on Family Violence	Commission	HJR 279 (1994) SJR 27 (1996) HJR 663 (1997)	Study domestic violence. Identify existing services and resources available to address family violence. Investigate ways to coordinate delivery of those services and resources and increase public awareness of their existence. Determine services, resources and legislation which may be needed to further address, prevent, and treat family violence.		30 members: 4 Del. appted by the Speaker; 3 Sen. appted by P&E; Lt. Gov.; Chief Justice of the Supreme Ct. or designee; Chief Judge of the Ct. of Appeals or designee; Atty. Gen. or designee; Sec. of Ed. or designee; 2 circuit ct. judges, 1 gen. dist. ct. judge & 1 juvenile and domestic relations ct.judge appted by Gov. from recs. of Chief Justice of Supreme Ct.; 1 juvenile and domestic relations ct judge appted by the Speaker; Comm. DMHMRSAS; Comm. DSS; Dir. of DJJ; Exec. Dir. of Public Defender Commission; 1 CA appted by P&E; 6 citizens representing media & org. involved in family violence issues, 4 by the Speaker and 2 by P&E.	Established 1994 as two-year commission, continued 1996, 1997. To submit findings and recommendations to the Gov. and the 1998 session of the General Assembly.

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
8	Commission on the Virginia Alcohol Safety Action Program	Commission	18.2-271.2	Establish and assure the maintenance of minimum standards and criteria for program operations; oversee performance, accounting, auditing, public information, and administrative procedures for the various local alcohol safety action programs, driver alcohol rehabilitation programs; and is responsible for overseeing the administration of the statewide VASAP system and reports directly to the Sec. of Transportation.		14 members: 3 current or former members of House Committee for Courts of Justice appted by Speaker; 2 members of Senate Committee for Courts of Justice appted by P&E; 3 sitting or retired judges, 1 each from circuit, gen. dist. & juvenile & domestic relations cts. who regularly hear or heard cases involving driving under the influence and are familiar with their local ASAP appted by chair of House Committee on District Courts; 2 dir. of local ASAP appted by legislative members of the commission; 1 rep of the law enforcement profession appted by the Speaker; 1 citizen at-large appted by P&E; 1 rep of DMV whose duties are substantially related to matters to be addressed by the commission, appted by the Comm. DMV; 1 rep of DMHMRSAS whose duties substantially involve such matters, appted by Comm. DMHMRSAS.	

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
9	Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation, and Substance Abuse Services	Subcommittee	HJR 240 (1996)	Examine and make recommendations on the current system of delivering mental health, mental retardation, and substance abuse services; the principles and goals for a comprehensive publicly funded mental health, mental retardation, and substance abuse services in the Commonwealth; the range of services, and eligibility for those services, necessary to serve Virginians' needs for publicly funded mental health, retardation and substance abuse services; the proper mentor of funding publicly supported community and facility mental health, mental retardation, and substance abuse services, including operations and capital needs and projecting the costs of meeting identified needs and revenue required; the proper relationship between DMHMRSAS and the components of the publicly funded system that delivers services, the Community Services Boards and the state facilities; the information, such as outcome and consumer satisfaction measures and comparable cost and utilization review data, and the technology needed to provide appropriate and enhanced accountability.		13 members: 7 Del. appted by Speaker; 4 Sen. appted by P&E; Sec. of HHR and Comm. of MHMRSAS as ex officio members	Established 1996; To submit findings and recommenda- tions to the Gov. and the 1998 session of the General Assembly

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
10	Joint Subcommittee Studying the Status and Needs of African-American Males in Virginia	Subcommittee	HJR 167 (1996) HJR 570 (1997)	Study the status and needs of African-American males and include in its deliberations the demographic profile of African-American males in Virginia; the representation of such males in the correctional institutions, under the supervision of the judicial system, enrolled as in-state students in public and private institutions of higher education in the Commonwealth; prevalent health problems and conditions of such persons in the state; the number of African-American males in the public education system, including the types of diplomas pursued and their representation in advanced level courses, vocational and technical education programs, college preparatory programs, and special education programs, their high school completion rates and kinds of completion credentials from both public and private schools and among the youth and adult correctional population; pass and fail rates of such males on measures of the Virginia State Assessment Program, and the number participating in and on the waiting list for the Literacy Incentive Program; and employment statistics for African-American males.	Depts. of Health, Education, Corrections, ans Social Services	9 members: 5 Del. appted by Speaker;4 Sen. appted by P&E; may consult with persons with expertise in psychiatry, the health care delivery system, social services, corrections, public and higher education, economic development, criminology, job training, community development, substance abuse prevention and treatment, family violence prevention, counseling, and such other persons who may assist the joint subcommittee in its work.	Established 1996; Continued 1997; To submit findings and recommenda- tions to the Gov. and the 1998 session of the General Assembly.

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
11	Advisory Commission on the Virginia Schools for the Deaf and the Blind	Commission	SB1125	Monitor operations of the Virginia Schools for the Deaf and the Blind and advise the Board of Education and submit recommendations to ensure the maintenance of a high-quality and cost-effective program of study and a safe and nurturing residential environment.	Depts. for the Visually Handicapped, Deaf and Hard-of-Hearing, Education	10 members: 5 Del. and 1 citizen member appted by the Speaker; 3 Sen. and 1 citizen member appted by P&E	Established 1997
12	Joint Legislative Audit and Review Commission	Commission	30-56	Carry out continuous legislative review and evaluation of the effectiveness and efficiency of state programs; make reports on findings and recommendations to the Governor and General Assembly concerning economical, efficient agency operation, and amelioration of agency services, and the elimination of duplicated or ineffective functions of state agencies. (Current and recent health related studies include examination of services for mentally disabled residents of adult care residences, review of the Comprehensive Services Act, review of the ADAPT system automating delivery of benefit services including Medicaid, and a review of Medicaid Forecasting Methodology.)		14 members: 9 Del. appted by Speaker of which at least 5 are members of the House Appropriations Committee; 5 Sen. appted by P&E of which at least 2 are members of the Senate Finance Committee; Auditor of Public Accounts as an ex officio member.	

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
13	Southeast Interstate Low-Level Radioactive Waste Management Compact Commission	Compact	10.1-1500	Provide the instrument and framework for a cooperative effort with the party states; provide sufficient facilities for the proper management of low-level radioactive waste generated in the region; promote the health and safety of the region; limit the number of facilities required to effectively and efficiently manage low-level radioactive waste generated in the region; encourage reduction of the amounts of low-level waste generated in the region; encourage and distribute costs, benefits, and obligations of successful low-level radioactive waste management equitably among party states.	Depts. of Health, Environmental Quality, Mines, Minerals and Energy	2 members from each member state appted by the respective Governors.	Established Sept. 10, 1982; may withdraw by enacting a law repealing the compact.

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
14	Southern States Energy Board	Compact	2.1-337	Foster progress in peaceful uses of nuclear energy within industry, education, and medicine, and plan interstate cooperation in the prevention and control of incidents.	Dept. of Mines, Minerals & Energy	3 members: 1 appted by the Gov., 1 appted by P&E, 1 appted by the Speaker.	May withdraw by enacting a statute repealing the compact & having the Governor send formal notice in writing to the gov. of ea. other party state; if any phrase, clause, sentence or provision of this compact or supplementary agreement is declared to be contrary to the constitution of any participating state or the United States

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
15	Joint Subcommittee Studying the Issues, Policies and Programs Relating to Infection with Human Acquired Immunodeficiency Syndrome	Subcommittee to House HWI, Courts of Justice, Corp., Insurance, & Banking, Education, & Appropriations and Senate Educ. & Health, Courts of Justice, Comm. & Labor, Rehab. & Social Services, & Finance	HJR 31 (1988) HJR 431 (1989) HJR 129 (1990) HJR 438 (1991) HJR 247 (1992) HJR 692 (1993) HJR 692 (1994)	Assess AIDS-related issues including: existing education programs and services to assist high-risk groups for AIDS; state policies concerning containment of the virus and care and treatment of persons living with AIDS; advisability of criminal statutes regarding the willful exposure of another to HIV by one so infected; efforts to prevent the spread of AIDS, including education, testing and isolation; voluntary and mandatory testing under various circumstances; discrimination and confidentiality issues related to AIDS; public education and child welfare issues relative to AIDS and AIDS-related illnesses; and health care and coverage for people with AIDS.	Depts. of Health, DSS, DMAS, Education	15 members: 1 member ea. from Sen. Committees on Education & Health, for Courts of Justice, on Commerce & Labor, on Rehabilitation & Social Services, & on Finance appted by P&E; 2 members of House Committee on Health, Welfare & Institutions, and one member ea. of the House Committees for Courts of Justice, on Corp., Insurance & Banking, on Education, & on Appropriations appted by the Speaker. One CA and 3 citizen members, 1 with expertise in research regarding infectious diseases, 1 with expertise in the care and treatment of AIDS and 1 with expertise in medical ethics, or an HIV-infected citizen or a citizen living with AIDS, to be appted by the Governor. Commissioners of Health, DSS, & DMHMRSAS; Dir. of DMAS, DOC, & Div. of Consolidated Laboratory Services; & the Superintendent of Public Instruction shall serve ex officio.	Established 1988; Continued 1989, 1990, 1991, 1992, 1993, 1994

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
16	Blue Ribbon Commission on School Health	Commission	SJR 155 (1994)	Collaborate in developing, implementing and evaluating statewide comprehensive school health programs. Study & make recommendations on all components of a comprehensive school health program, including health education; health services; healthful school environment; parent/community involvement; counseling, psychological & social services, nutrition services; physical education; & health promotion for staff.	Depts. Of Health, Education, DMHMRSAS	15 members: 2 Sen. appted by P&E; 2 Del. appted by Speaker; 1 member ea. from Depts. of Education, Health, Youth & Family Services, & DMAS appted by the Governor. 2 members from the business sector, 2 reps from health care associations, 2 reps from local education associations, & 1 rep from PTAs, all appted by the Governor.	Established 1994
17	Joint Subcommittee to Study the Effects of Deinstitutionalization	Subcommittee to House and Senate committees et al	HJR 139 (1994) HJR 549 (1995)	Examine the issue of deinstitutionalization and its effect on the patient and the locality.	DMHMRSAS	13 members: 4 Del. appted by Speaker; 3 Sen. appted by P&E; Comm. of DMHMRSAS; 1 rep from CSB, 2 reps of mental health patient interests & 2 reps of local gov't interest, all appted by the Governor.	Established 1994; Continued 1995

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
18	Joint Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities	Subcommittee	HJR 164 (1990) HJR 380 (1991) HJR 187 (1992) HJR 187 (1992) HJR 196 (1994) HJR 551 (1995) HJR 581 (1997)	Study ways of funding early intervention services, including expanding the use of Medicaid; ways of increasing interagency participation in establishing, providing and funding early intervention services; ways of reaching populations that are underserved because of cultural diversity; impact of serving at-risk children; remedies for shortages of personnel providing early intervention services.	Depts. of Rights of Virginians w/Disabilities, DMAS, DMHMRSAS	11 members: 5 Del. appted by Speaker; 3 Sen. appted by P&E; 3 citizen members appted by the Governor.	Established 1990; Continued 1991, 1992, 1993, 1994, 1995, 1996, 1997; To submit findings and recommendations to the Gov. and the 1999 session of the General Assembly

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
19	Commission on the Coordination of the Delivery of Services to Facilitate the Self-sufficiency and Support for Persons with Physical and Sensory Disabilities in the Commonwealth	Commission	HJR 45 (1990) SJR 186 (1991) HJR 257 (1992) HJR 429 (1993) HJR 274 (1994)	Review and determine measures and incentives that provide for accountability and support coordinated services for persons with physical and sensory disabilities; develop strategies for optimum use of public and private fiscal resources and insurance; determine methods to address the gaps in eligibility criteria for services and the service delivery system that inhibit access to needed services and employment opportunities; develop human resource models to facilitate rehabilitation-oriented case man-agement and other professional support for persons with physical and sensory disabilities; evaluate the need for and recommend strategies for research and a system to provide post-acute and long-term rehabilitation for traumatic injury and specified disability groups; identify and develop service delivery models to address the multi-faceted and long-term needs for treatment, community support, transportation, housing, employment, job training, vocational and career counseling, and job placement services; and determine ways to promote coordination.	Virginia Board for People with Disabilities, Depts. for Rights of Virginians w/ Disabilities, Visually Handicapped, Deaf and Hard-of-Hearing, DRS DMAS	16 members: 5 Del. appted by Speaker; 1 member ea. from Sen. Committees on Education & Health, on Rehabilitation and Social Services, & on Finance appted by P&E; 1 member ea. from the business community, health insurance industry, and health care industry, 1 educator certified in special education, 1 licensed practicing physician with experience in emergency medicine and trauma care or neurosurgery, 1 citizen at-large all appted by the Gov.; Lt. Gov.; 1 former Sen. representing the 25th Senatorial District from January 1980 until December 1991, & the former chairman of the House Committee on Health, Welfare & Institutions representing the 76th House District from January 1970 until December 1991.	Established 1990; Continued 1991, 1992, 1993, 1994

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
20	Virginia Workers' Compensation Commission	Independent agency	65.2-200	Administer Workers' Compensation Act and adjudicate cases thereunder; and have jurisdiction over accidental injury and occupational disease arising out of and in the course of employment.		3 members elected by joint vote of both houses of the General Assembly	

Table 8. Health Policy-Related Commissions and Committees Composed of Legislators or Appointed by the Legislature

#	Title	Legislative Classification	Code or Bill	Mission/Purpose	Potential Link to Executive Branch Boards	Member Composition	DURATION: Date Initiated; Sunset Clause, or Standing
21	Commission on the Reduction of Sexual Assault Victimization in Virginia	Commission	SJR 108 (1992) SJR 277 (1993) SJR 56 (1994)	Examine existing treatment resources in both community and institutional environments for juvenile sex offenders and in community-based programs for young victims of sexual abuse. Develop cost-effective methods for coordination and expansion of treatment services; develop strategies for the identification and education to children who have been victims of sexual assault or are ate risk of sexual victimization; review research on sexual assault and abuse to determine the relationship between childhood sexual victimization and later sexual offender behavior and develop strategies to prevent this behavior; identify discrepancies in service and funding needs and develop recommendations for addressing these discrepancies through public and private resources; study Virginia's sexual assault laws and determine if they should be amended; review the sexual assault laws of other states and federal laws.	Depts. Of Corrections, DMHMRSAS DJJ, DRS	14 members: 2 Sen. appted by P&E; 3 Del. appted by Speaker; rep from the Office of the Atty Gen.; Lt. Gov.; 3 citizen members appted by the Gov.; Secretaries of HHR, Education, & Public Safety and Executive Secretary of the Supreme Court as ex-officio members.	

SOURCES: Commonwealth of Virginia, Office of the Secretary of the Commonwealth, 1996-1997 Report of the Secretary of the Commonwealth to the Governor and General Assembly of Virginia (Richmond, VA: 1996).

Table 9. Summary Membership Profile of Committees and Commissions Composed of Legislators or Appointed by the Legislature

Categories	Number of Board Members	Percentage of Total Board Members
Legislators	168	62%
Professionals	68	25%
Citizens	34	13%
Total	270	100%

Table 10.
Major Health Issues Resulting for Medicaid Reforms

- ❑ Who is eligible to receive services
- ❑ Effect on service providers
- ❑ When citizens seek services
- ❑ Determining community needs
- ❑ Citizen expectations with respect to service delivery
- ❑ Locus of service - state, regional, or local
- ❑ Preparation of professionals

Table 11.
Key Factors in Successful Health Planning

- ❑ Leadership across the executive and legislative branches of government
- ❑ Broad-based stakeholder involvement
- ❑ Availability of accessible and technically sound information
- ❑ Early and continuous involvement in the planning process
- ❑ Comprehensive planning body
- ❑ Using a *public* planning process

Appendix 1.
Senate Joint Resolution 317

SENATE JOINT RESOLUTION NO. 317

Requesting the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care, to review the various boards, advisory boards, commissions, committees and councils identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations or restructuring of these entities.

Agreed to by the Senate, January 30, 1997
Agreed to by the House of Delegates, February 13, 1997

WHEREAS, Senate Joint Resolution No. 104 of the 1996 Session of the General Assembly directed the Joint Commission on Health Care to review and make recommendations concerning the Commonwealth's numerous governmental, not-for-profit, and independent entities receiving state funds or having responsibilities for health care policy or regulation; and

WHEREAS, the Joint Commission on Health Care identified 63 such entities receiving state funds or having responsibility for health care policy or regulation, including various health care policy-setting boards, advisory boards, commissions, committees, and councils; and

WHEREAS, the Joint Commission on Health Care found that there is little interaction among the various boards, commissions, committees, and councils; and

WHEREAS, some of the existing entities meet very infrequently and some, such as the Virginia Health Planning Board and the Psychiatric Advisory Board, have not met in several years and may no longer need to be continued in their current capacity and structure; and

WHEREAS, there currently is no active entity within the Executive Branch of government with clear authority for coordinating statewide health policy; and

WHEREAS, there may be opportunities for revising, consolidating, or restructuring these entities; and

WHEREAS, most of the existing entities fall within the Secretariat of Health and Human Resources; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Health and Human Resources, in cooperation with the Joint Commission on Health Care, be requested to review the various boards, advisory boards, commissions, committees, and councils identified by the Joint Commission on Health Care and recommend any appropriate revisions, consolidations, or restructuring of these entities.

The Secretary shall submit his findings and recommendations to the Governor and the Joint Commission on Health Care by October 15, 1997, and to the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Go to (General Assembly Home)

Appendix 2.

Letter from Robert C. Metcalf, Secretary of Health and Human Resources, to Senator Stanley C. Walker, Chairman of the Joint Commission on Health Care October 22, 1996

COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Robert C. Metcalf
Secretary of Health and Human Resources

October 22, 1996

The Honorable Stanley C. Walker
Chairman, Joint Commission on Health Care
General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Senator Walker:

This letter is in response to the recent staff report on SJR 104, *Study of the Various Entities Receiving State Funds or Having Responsibilities of Health Care Policy and Regulations.* As you know, this study in its initial phase focuses on the potential overlapping missions of boards, commissions, committees and councils (boards). The resolution directs the Joint Commission on Health Care to conduct its studies "in consultation with the Secretary of Health and Human Resources." I will begin with a few general observations on the staff report before making specific comments on its policy options.

Boards are crucial to governance in this Administration because these supervisory, policy, and advisory boards provide opportunities for citizen and professional involvement in state government. Moreover, they serve to decentralize decision making, extending the opportunity to influence the Commonwealth's laws and policies to the local and community level. To assure that citizen and professional involvement leads to meaningful action, the Administration continually reviews the necessity and effectiveness of each board. I am not surprised that a principal finding in the staff report cited the current number, structure, missions, and functions of the respective boards, as appropriate. This Administration has, from time to time, sought to eliminate boards when it judged, after careful consideration, a board to be unnecessary, redundant in function, or ineffective in some manner. In fact, Executive Order Number One (94) charged the Governor's Commission on Government Reform to review all state agencies, programs and activities, including boards and commissions, to determine those that best serve the needs of Virginians and to abolish or consolidate those boards that were unnecessary or duplicative.

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There is an adequate level of Administration leadership in this area, though I am sure that we can still do more to enhance citizen and professional involvement in government. Increased efforts to promote collaborative initiatives to improve the health of citizens of Commonwealth, for example, need to be explored. This would be in keeping with the report's finding that there was relatively little interaction among the various boards. No doubt, this is largely attributable to the specific mission that many of these boards have. Another reason why there is little interaction between these boards may stem from the absence of such instruction in the enabling legislation. I can easily imagine how these two factors could converge to contribute to the lack of interaction among these boards. However, I would caution that if these boards become preoccupied with interacting among themselves they could fail to perform their principal statutory obligation.

Bearing in mind these general observations, I will turn now to specific comments on the policy options identified in the report.

Option I: Take No Action.

HHR has no response to option one at this time.

Option II: Introduce a Study Resolution Directing the Secretary of Health and Human Resources to Review the Inventory of Boards, Commissions, and Councils Presented in this Issue Brief, and Recommend to the Governor, the Joint Commission on Health Care and the General Assembly Any Appropriate Revisions, Consolidations or Re-structuring of these Entities. The Study Also Could Include a Review of the Various Agencies within the Health and Human Resources Secretariat.

We support this option. The Secretariat's agency heads have reviewed, and will continue to review, the functioning of the boards affecting their agency. All agency heads in this Secretariat meet bi-weekly. To assure better interaction among these boards, the agency heads will discuss how we as a Secretariat can enhance collaboration across the agencies. To facilitate improved interaction among the boards that fall under a single agency, I plan to ask the board most responsible for health policy of the entire agency (e.g. the Board of Health at the Department of Health, and the Board of Medical Assistance Services at the Department of Medical Assistance Services) to take the leadership in reviewing the mission and activities with the respective health related boards within the Secretariat. In light of the fact that we will continue to pursue this effort, I suggest that the Joint Commission on Health Care work in conjunction with the

Secretary of Health and Human Resources to study the current health policy boards and develop recommendations for the Governor and the 1998 General Assembly.

Option III: Introduce a Resolution Directing the Secretary of Health and Human Resources to: (I) Re-convene the Virginia Health Planning Board; (ii) Assess the Continued Need for the Board; and (iii) Report to the Governor, the Joint Commission on Health Care and the General Assembly Whether the Board should be Continued or Eliminated.

The last meeting of the Virginia Health Planning Board was held in November, 1991. Apparently, Governor Wilder's Secretary of Health and Human Resources, Howard Cullum, did not see the necessity for further meetings of the Virginia Health Planning Board.

Because of the duty to protect the "safety net" of health and social services for vulnerable citizens in the Commonwealth, I have continued with this Administration's precedent of overseeing important health policy issues primarily through boards such as the Board of Medical Assistance Services, State Board of Health, State Mental Health, Mental Retardation and Substance Abuse Services Board, the Board of Rehabilitative Services, and others, as well as the their respective agency staff. I would add the Governor's Maternal and Child Health Council (MCHC) as another entity with focus on a critical population. The MCHC, in concert with these agencies' boards, continues to have a vital role in guiding activities that are critical to coordinating welfare reform and health care. As the staff report presented, both Joe Teefey, Director of the Department of Medical Assistance Services and Dr. Randy Gordon, Commissioner, Virginia Department of Health. are satisfied with the existing structure and functions for health policy development without input from the Virginia Health Planning Board. Furthermore, the functions of the Virginia Health Planning Board are covered by the work of the State Board of Health, Regional Health Systems Agencies, the Office of Health Facilities Regulation which includes the Division of COPN, and vestiges of a health policy function in VDH, including a focus on primary care. Thus, activating the Virginia Health Planning Board may be duplicative of existing boards.

Finally, I look to the Virginia Department of Health and the Department of Medical Assistance Services as the principal health policy development bodies in the Secretariat. I believe it is an important core function of public health to exert leadership for health policy development in this Administration both at the state level and at the community level through the local health departments, primarily in the areas of quality of services and primary care access. Without relevant information from the Secretariat's efforts to continually review the function of the health policy boards. any specific action

with respect to re-convening the Virginia Health Planning Board would be premature at this time.

Option IV: Introduce Legislation to Eliminate the Virginia Health Planning Board.

HHR has no response to option four at this time.

Option V: Endorse and Support the Department of Medical Assistance Services' Efforts to Re-structure the Advisory Committee on Medicare And Medicaid.

The Department of Medical Assistance Services has proposed legislation to eliminate the Advisory Board on Medicare and Medicaid by consolidating its responsibilities with those of the Board of Medical Assistance Services. The proposal also recommends a membership change in the Board of Medical Assistance Services to accommodate federal regulations. As a possible alternative, the proposal contains a provision to reduce the size of the Advisory Board on Medicare and Medicaid from 21 to 11 members, and would remove all references to Medicare within its enabling legislation.

I would certainly appreciate the support of the Commission for actions that the Department of Medical Assistance Services determines to be appropriate for this advisory board.

Thank you for the opportunity to comment on this study. I trust that my counsel will be helpful to your final deliberations.

Sincerely,

Robert C. Metcalf

cc: Agency Heads

Appendix 3. Agency Contacts in the Commonwealth of Virginia

Board for People with Disabilities
Barbara Ettner

Department for the Aging
Thelma Bland
Bob Knox

Department for the Deaf and Hard of Hearing
Leslie Hutchison

Department for the Visually Handicapped
Bill Pega

Department of Education
Douglas Cox
Lissa Power-Defur
Fran Meyer

Department of Health
Paul Matthias
Gary Brown
Nancy Bullock
Jim Thompson
Marcella Fierro
Casey Riley
Elaine Martin
Kathy Hafford
Barbara Bingham
Eileen Malec

Department of Health Professions
Bob Nebiker

Department of Medical Assistance Services
Roberta Jonas

Department of Mental Health, Mental Retardation and Substance Abuse Services
Martha Mead

Appendix 3. Agency Contacts in the Commonwealth of Virginia (continued)

Department of Rehabilitative Services
Kathy Hayfield
Ken Knorr

Joint Commission on Health Care
Patrick Finnerty

Secretary of Health and Human Resources
Jeff Wilson

Department for the Rights of Virginians with Disabilities
Ava Thomas
Heidi Lawyer

Bureau of Insurance
Raquel Pino-Moreno

Department of Social Service
Larry Mason
Terry Smith
Leslie Anderson

Department of Professional and Occupational Regulation
David Dick

Department of Personnel and Training
Carol Ray
Margaret Cashion-Hudson

Department of Labor and Industry
John Crisanti
Patti Bell

State Executive Council for At-Risk Youth and Families
Allan Saunders

Department of Motor Vehicles
Millicent Ford

Virginia Birth-Related Neurological Injury Compensation Program
Elinor Pyles
Lisa Antis

Appendix 4.

Memo from Robert C. Metcalf, Secretary of Health and Human Resources, to Agencies About Senate Joint Resolution 317, July 9, 1997

COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Robert C. Metcalf
Secretary of Health and Human Resources

July 9, 1997

MEMORANDUM

TO: Department for the Aging
Department for the Rights of Virginians with Disabilities
Virginia Department for the Deaf and Hard of Hearing
Department of Education
Virginia Department of Health
Department of Health Professions
Bureau of Insurance
Department of Medical Assistance Services
Department of Mental Health, Mental Retardation, and Substance Abuse Services
Department of Personnel and Training
Department of Professional and Occupational Regulations
Department of Rehabilitative Services
Department of Social Services
Department for the Visually Handicapped
Virginia Board for People with Disabilities

FROM: Robert C. Metcalf

SUBJECT: Senate Joint Resolution 317 - Study of Health Care-Related Boards

Senate Joint Resolution 317 (1997) requests the Secretary of Health and Human Resources, in conjunction with the Joint Commission on Health Care (JCHC) to review the various boards, advisory boards, commissions, committees, and councils identified by the JCHC and recommend any appropriate revisions, consolidations, or restructuring of these entities. The organizations identified by the JCHC are discussed in Appendix B of Senate Document No. 8 (1997), which is attached.

I have designated the Department of Medical Assistance Services (DMAS) as the lead agency to coordinate this study. DMAS will be working with the College of William and Mary's Center for the Public Policy Research (CPPR) in the Thomas Jefferson Program in Public Policy to report any findings and recommendations to me.

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To assist in this effort, please transmit to DMAS by Friday, July 11, the names of the lead staff person within your agency for this project. This will be the person with whom DMAS and CPPR will coordinate directly. In addition, please update Appendix B of Senate Document No. 8 with any revision, additions, or deletions by Friday, July 18. Also, please indicate any current activities regarding changes to the roles, responsibilities, functions or duties of the boards as appropriate. Please include any recommendations you might have regarding each board and any individuals or organizations that might have particular interest in your recommendations.

The policy analyst at DMAS responsible for coordination of this project is Bobbie Jo Jonas. Any questions regarding this study can be directed to her at 371-8854 or Jeff Wilson in this office at 786-7765.

cc: Secretary Beverly Sgro
Secretary Robert Skunda
Secretary Michael Thomas
Pat Finnerty, JCHC
David Finifter, Ph.D., Director, CPPR

Enclosures

Appendix 5.

Responses from Agency Contacts to Update the Board Inventory

COMMONWEALTH of VIRGINIA

Department of Health Professions

John W. Hasty
Director

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9900
FAX (804) 662-9943
TDD (804) 662-7197

July 18, 1997

MEMORANDUM

TO: Bobbie Jo Jonas

FROM: Robert A. Nebiker
Senior Deputy Director

SUBJECT: SJR 317 (1997)

Please find attached an update to Appendix B, pages 7-12, dealing with boards and committees affiliated with the Department of Health Professions. Especially note that three have been added. The Boards of Dentistry and Rehabilitation Providers were omitted from the previous report. The "Intervention Program Committee" was added by Chapter 439 of the 1997 Acts of Assembly.

We continue to believe that elimination of the Psychiatric Advisory Board specified in § 54.1-2924 is appropriate.

Do not hesitate to contact me if you have any questions.

cc: John W. Hasty
Jeff Wilson

BACKGROUND PAPER FROM
THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Explaining the Department's Recommendations for
Eliminating the Advisory Board on Medicare and Medicaid

BACKGROUND PAPER

Topic: Advisory Board on Medicare and Medicaid and the State Board of Medical Assistance Services.

Origin: Federal regulation at 42 CFR 431.12 requires the State Plan for Medical Assistance Services to provide for a Medical Care Advisory Committee. This section was adopted in the 1970's for the purpose of establishing a committee to advise the Medicaid agency director about health and medical care services. At the time this regulation was adopted, Medicaid agencies were primarily organizational units under other state departments, mainly under state departments of social services or health. The requirement for a medical care advisory committee to advise the Medicaid agency director about health and medical care services was necessary at that time since most Medicaid agencies were not independent agencies and as such did not have policy boards and/or advisory committees charged with focusing on Medicaid-related issues.

To meet the requirement of federal regulation, Chapter 711 of the 1979 Virginia Acts of Assembly established the Advisory Committee on Medicare and Medicaid for the purpose of advising the Governor on responsibilities of the Commonwealth under Titles XVIII and XIX of the United States Social Security Act and of assisting the Board and the Commissioner of Health in developing the plan and method of administration for the medical assistance program. The committee consisted of no more than twenty one persons. The State Health Commissioner, the Commissioner of Mental Health and Mental Retardation and the Director of the Department of Welfare were designated to serve as ex-officio members and the Governor appointed the remaining members of the committee from nominations submitted by specified organizations.

Since the 1970's numerous changes have occurred in the organizational structure of Medicaid agencies and several states have established independent agencies and boards charged with the responsibility for preparing, amending, submitting and administering a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act. Virginia established an independent Medicaid agency on March 1, 1985 when administration of Medicaid was separated from the Department of Health and the Department and Board of Medical Assistance Services were created by statute. Also in 1985, the Advisory Committee on Medicare and Medicaid was continued as the Advisory Board on Medicare and Medicaid to advise the Governor on the Commonwealth's responsibilities under Titles XVIII and XIX of the Social Security Act and for assisting the Board and Director of Medical Assistance Services in developing the plan and method of administration for the medical assistance services program. The Director of Medical Assistance Services was added as a designated ex officio member of the Advisory Board.

The Board of Medical Assistance Services is a policy board, and authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act. The primary purpose of the Board is to ensure that the categorically and medically needy citizens of the Commonwealth have financial access to a cost effective, comprehensive health care delivery system. By statute, the Board is required to work cooperatively with the Board of Health to ensure that quality patient care is provided. The Board is composed of eleven residents of the Commonwealth, five of whom are health care providers and six of whom are not, and all are appointed by the Governor for terms of four years; no member is eligible to serve more than two consecutive full terms. The Director of the Department of Medical Assistance Services is the executive officer of the Board but not a member thereof.

Situation: Since the establishment of the Board of Medical Assistance Services in 1985, the charges of the medical care advisory committee as specified in 42 CFR 431.12 have been subsumed by the Board of Medical Assistance Services and the Advisory Board on Medicare and Medicaid has been nonfunctiona given its duplicative role. The Board of Medical Assistanc Services meets the regulatory requirements for a medical care advisory committee as specified in 42 CFR 431.12 (attachment) except for (i) the requirement for representation of consumers' groups, including Medicaid recipients as specified in §431.12 (d)(2) and (ii) the requirement that the director of the public welfare department or public health department, whichever does not head the Medicaid agency, serve as a member of the committee as specified in §431.12 (d)(3). Furthermore, since Medicare is completely administered and funded by the federal government, there is no direct role for the Advisory Board on Medicare and Medicaid with regard to Title XVIII.

In order to comply with federal regulation, the membership of the Board of Medical Assistance Services would need to include members of consumers' groups, including Medicaid recipients and representation by either the Commissioner of the Department of Social Services or the Commissioner of Health.

In accordance with §32.1-324 of the Code of Virginia, the Board consists of eleven residents of the Commonwealth, five of whom are health care providers and six of whom are not. There is nothing in the statute which would preclude the appointment of a consumer representative to the Board as a non health care provider.

At present, there are no vacancies on the eleven member Board of Medical Assistance Services; however, the term of one of the health care providers is scheduled to expire on March 7, 1992 and

two of the non-providers' terms are scheduled to expire on February 28, 1992 and March 7, 1992, respectively.

In order for the composition of the Board of Medical Assistance Services to comply with federal regulation, the following options are available:

1. A consumer representative could be appointed to fill the next non-provider vacancy on the Board (two such terms are scheduled to expire in the next several months, on February 28 and March 7, 1992) and the Commissioner of Health could be appointed as an ex officio member of the Board. Legislative action would not be required to alter the number of voting members serving on the Board; however, §32.1-324 would need to be amended to specify that the State Health Commissioner shall serve as an ex officio member. It is recommended that the Commissioner of Health rather than the Commissioner of Social Services be appointed as a member since by statute (Va. Code §32.1-325) the Board is required to work cooperatively with the State Board of Health to ensure that quality patient care is provided. This option would ensure compliance with federal regulation and would not alter the existing balance of provider/non-provider voting members on the Board. Legislative action would be required to repeal §32.1-328, the Advisory Board on Medicare and Medicaid.

2. A consumer representative could be appointed to fill the next non-provider vacancy on the Board (two such terms are scheduled to expire in the next several months, on February 28 and March 7, 1992) and the Commissioner of Health could be appointed to fill the next health care provider vacancy on the Board (the next such term is scheduled to expire on March 7, 1992). It is recommended that the Commissioner of Health rather than the Commissioner of Social Services be appointed as a member since by statute (Va. Code §32.1-325) the Board is required to work cooperatively with the State Board of Health to ensure that quality patient care is provided. Legislative action would not be required to amend the composition of the Board's membership; however, the provider community may feel that they would lose representation on the Board if a state agency head (Commissioner of Health) served as a provider representative. Legislative action would be required to repeal §32.1-328, the Advisory Board on Medicare and Medicaid.

3. Legislation could be enacted to expand the membership of the Board to allow for the appointment of a consumer representative and for the appointment of the Commissioner of Health or the Commissioner of Social Services. If this option is selected, it is recommended that the membership of the Board be expanded from 11 to 13 residents of the Commonwealth and that one of the new members be designated by statute to represent consumers' groups, including Medicaid recipients, and that the other representative be either the Commissioner of Health or

Social Services. Legislation would also be required to repeal § 32.1-328, the Advisory Board on Medicare and Medicaid.

Objective: To eliminate duplicative functions of two State Boards and ensure compliance with federal regulation.

Approach: In order to satisfy the requirement of 42 CFR 431.12 for a medical care advisory committee, the Department of Medical Assistance Services recommends that the membership of the Board of Medical Assistance Services include a representative of consumers' groups with such representative being appointed at the next available opportunity for appointment of a non-provider representative. It is further recommended that legislation be enacted to amend §32.1-324 of the Code of Virginia to designate the State Health Commissioner an ex officio member of the Board and that §32.1-328 of the Code of Virginia relating to the Advisory Board on Medicare and Medicaid be repealed.

Outcome: Elimination of duplicative functions; reduction in the number of State Boards; and ensured compliance with federal regulation related to the State Plan for Medical Assistance.

Resources Requirements: None

REFERENCES:

1. 42 CFR 431.12 Medical care advisory committee.

2. Letters to and from Christine Nye, Director, Medicaid Bureau, Department of Health & Human Services.

3. Section 32.1-324, Board of Medical Assistance Services.

4. Section 32.1-328, Advisory Board on Medicare and Medicaid.

REVIEWED/AUTHORIZATION TO COMMENCE:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

COMMONWEALTH of VIRGINIA

Department of Health

RANDOLPH L. GORDON, M.D., M.P.H.
COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

MEMORANDUM

TO: The Honorable Robert C. Metcalf
Secretary of Health and Human Resources

FROM: Randolph L. Gordon, M.D., M.P.H.
State Health Commissioner

DATE: July 18, 1997

SUBJECT: Senate Joint Resolution 317 - Study of Health Care-Related Boards

In response to your memorandum of July 9, 1997, on the above referenced subject, I have attached an updated portion of Appendix B as it relates to those boards, commissions, committees and councils affiliated with the State Department of Health. Changes made to the original document which accompanied your correspondence appear in bold on this attachment. You will note that there is one additional entity, the Commonwealth Neurotrauma Initiative Advisory Board, that appears at the end of the chart; this body was created by the 1997 General Assembly.

With regard to recommendations and background information pertaining to several of these bodies, I offer the following:

Regional EMS Councils

Section 32.1-111.11 of the *Code* establishes Regional EMS Councils. This section was amended in 1990 and requires the Board of Health to promulgate regulations that include but are not limited to, requirements to ensure accountability of public funds, criteria for matching funds and performance standards. Unfortunately, no action has been taken on this statute until recently. The law also requires the Board of Health to designate regional EMS councils, which it first did in 1980. The 1990 amendments require a designation process, application and review every three years. The Office of EMS (OEMS) has developed draft regulations, a Designation Process/Manual and performance standards. It is anticipated that a pre-NOIRA will be filed within the next 60 days.

OEMS strongly recommends the adoption of regulations as required by the *Code*. It also recommends a review of current designated regional councils and restructuring as appropriate. Included in the review should be alternatives for realignment of service areas, staffing and

contractual requirements between OEMS and the regional councils, and an analysis of the State positions (FTEs) needed to comply with the established performance standards. OEMS believes that information from such a review could enable it to improve the efficiency and efficacy of its operations as they pertain to the regional EMS councils.

Virginia Health Planning Board

Arguments can be made for or against reactivating the Virginia Health Planning Board, however, I believe it should be an issue for the next governor to decide since he appoints the members and it is a panel whose authority transcends any one agency.

Home Care Services Advisory Committee

Given the fact that this body has not met for a decade, its abolishment would be no great loss. Functions that it might be expected to have are being addressed by the Virginia Association for Home Care.

Human Research Review Committees

There have been no changes to the mandated roles, responsibilities, functions or duties of the Human Research Review Committees. No revisions, consolidations, or restructuring of these committees is recommended at this time. It is believed that health departments, nursing homes and most hospitals do not normally or presently conduct human research. Those hospitals conducting human research are the medical centers, which are exempt from Section 32.1-162.19 of the *Code of Virginia* since they follow the federal regulations for human research. Therefore, in practice, the existing *Code* provisions and related regulations have had no impact on regulated entities. Nonetheless, it is recommended that they be maintained to ensure protection of the rights and welfare of human research participants should research be initiated in the future.

This recommendation is not based on a recent assessment of Human Research Review Committees; it is based on the review of the Regulations for the Conduct of Human Research conducted in May, 1995 pursuant to Executive Order 15. The following individuals were involved in this review: Susan Ward, Vice President, Virginia Hospital and Healthcare Association (804-747-8600), Marcia Easterling, Administrator, Elizabeth Adam Crump Manor Nursing Home (804-672-8725), Karen Head, Critical Care Coordinator, Office of Emergency Services, Department of Health (371-3500), Joshua Lipsman, MD, District Director, Alexandria Health District (703-838-4872), and Rosanne Kolesar, Acting Executive Advisor, Department of Health (804-786-2011). Prior to finalizing a recommendation relative to Human Research Review Committees, this group should be reconvened and a review conducted.

It is our position that the remaining entities on the list are viable ones and we do not have any additional recommendations regarding them at this time.

Please feel free to contact my office if we may provide any further information or clarification relative to this effort.

Attachment

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation: Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Board of Health	§32.1-5	Provide leadership in health planning and policy development for the Commonwealth and DOH; implement a coordinated prevention-oriented program that promotes and protects the health of all Virginians.	11	Medical Society of Virginia (2); Virginia Pharmaceutical Assoc. (1); State Dental Association (1); Virginia Nurses' Association (1); Virginia Veterinary Medical Assoc. (1); Local Government (1); Hospital Industry (1); Nursing Home Industry (1); Consumers (2).	Governor	4/yr.
State Emergency Medical Services Advisory Board	§32.1-111.10	Advise the Board of Health, and review and make recommendations on the Statewide EMS Plan	24	1 each: Virginia Municipal League and Virginia Association of Counties; Numerous medical/emergency/ nursing associations; 1 consumer.	Governor	≥ 4/yr.
Regional EMS Councils	§32.1-111.11	Receive and disburse public funds; develop and implement regional EMS delivery system	Not specified	Local government, fire protection, law enforcement, EMS agencies, hospitals, physicians, emergency nurses, EMS technicians, mental health and other appropriate medical professionals	Board of Health designates Regional Councils	**Varies among the 8 regional EMS councils**

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Financial Assistance and Review Committee	§32.1-111.12.01	Administer the Rescue Squad Assistance Fund, review grant applications and make recommendations for funding	6	Representatives of regions encompassed by Regional EMS Councils	State EMS Advisory Board	6/yr.
Virginia Health Planning Board	§32.1-122.02	Supervises and provides leadership for the state health planning system; provides technical expertise in developing state policy; makes recommendations on health policy, legislation, resource allocation, and statewide data collection for health care manpower distribution and for mortality and morbidity rates; promulgates regulations as necessary	18	8 consumers; 4 providers; Commissioner of Health; Commissioner of DMHMRSAS; Director, Department for the Aging; Director, DMAS; Commissioner of Social Services; Secretary of Health and Human Resources (serves as chairman).	Governor	Has not met in several years

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation: Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Regional Health Planning Agencies/Boards	§32.1-122.05	Assist Health Planning Board: conduct data collection and research; prepare reports; conduct needs assessments; identify gaps in services; review Certificate of Public Need applications	≤30	Consumers, providers, a director of local health department/director of social services department, CSB, Area Agency on Aging, health care insurers, local government, business representative, academic community. Majority must be consumers.	State Health Planning Board establishes procedures for appointments	**Varies among the 5 regional boards from 4-12/yr.**
Home Care Services Advisory Committee	§32.1-162.14	Advise and make recommendations to the Board of Health on implementation and administration of laws pertaining to home health services	10	4 representatives of home care organizations; 2 citizens; 1 representative each from DSS, Department for the Aging, DMAS, and DRS.	Commissioner of Health	**Has not met in 10 years**
Human Research Review Committees	§32.1-162.19	Ensure competent, complete and professional review of human research activities of institutions conducting human research	Not Specified	Representatives of varied backgrounds	Each institution conducting human research	Unknown

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Hemophilia Advisory Board	§32.1-89	Consult with the Board of Health in establishing and administering a program for care and treatment of persons with hemophilia and related diseases who are unable to pay entire cost of services despite existence of insurance	7	1 each: hospitals, medical schools, blood banks, volunteer agencies interested in hemophilia, local public health agencies, medical specialists in hemophilia, and the general public	Governor	≥ 1/yr.
State Health Department Sewage Handling and Disposal Appeal Review Board	§32.1-166.1	Hear all administrative appeals of denials of onsite sewage disposal system permits; make recommendations for alternative solutions in denial of permit	7	Persons with various backgrounds in soil analysis and sewage treatment	Governor, subject to confirmation by General Assembly	8/yr.

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation: Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Virginia Voluntary Formulary Board	§32.1-80	Evaluate scientific data to determine which generic drugs are interchangeable with brand-name drugs (approved products are included in formulary); make formulary available to providers of health care and others; disseminate information to encourage appropriate use	12	4 physicians; 2 pharmacists; 1 biopharmaceutist; 1 dentist; Chairman of Pharmacology at VCU; Administrator of Consumer Affairs, Dept. Of Agriculture and Consumer Affairs; 1 member of the public Attorney General (ex officio)	Governor	Every 3 months or upon call of 2 officers or the Commiss-ioner of Health

APPENDIX B

HEALTH CARE-RELATED BOARDS,
COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation: Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
State Child Fatality Review Team	§32.1-283.1	Develop and implement procedures to ensure that child deaths in Virginia are analyzed in a systematic way; recommend prevention, education and training programs	16	Commissioner of DMHMRSAS; Director of Child Protective Services, DSS; Superintendent if Public Instruction; State Registrar of Vital Records; Director, Department of Criminal Justice Services; 1 each: local law enforcement, local fire departments, local departments of social services, Medical Society of Virginia, Virginia College of Emergency Physicians, Virginia Pediatric Society, Virginia SIDS Alliance, local emergency medical personnel, Commonwealth's attorneys, Community Service Boards. Chief Medical Examiner is chairman.	Governor	6/yr. Additional meetings as needed
AIDS Advisory Board	§32.1-11.1	Assist in the development of criteria for awarding AIDS education grants	3-5	Experts in the delivery of services to persons with AIDS and AIDS education	Board of Health	As needed
Nursing Scholarships Advisory Committee	§23-35.9	Awards nursing scholarships for undergraduate and graduate nursing students in conjunction with the Board of Health	8	4 deans or directors of schools of nursing; 2 past nursing scholarship recipients; 2 persons with experience in administration of student financial aid programs	Board of Health	1-2/yr.

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Virginia Transplant Council	§32.1-297.1	Conduct educational and informational activities as they relate to organ and tissue procurement and transplantation	18	**1 each from Bone Marrow Transplantation Programs at MCV Hospitals, Virginia Blood Services, and UVA Medical Center; Carolina Organ Procurement Agency; INOVA Fairfax Hospital; Henrico Doctors' Hospital; Lifenet; Life Resources Regional Donor Center; Lions' Medical Eye Bank and Research Center of Eastern Virginia; MCV Hospitals; Old Dominion Eye Bank; Roanoke Memorial Hospitals; Sentara Norfolk General Hospital; South-Eastern Organ Procurement Foundation; UVA Health Sciences Center; Virginia Hospital and Healthcare Association; Virginia's Organ Procurement Agency Washington Regional Transplant Consortium**	Each participating entity	4/yr.

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

Agency Affiliation: Department of Health

ENTITY	CODE AUTHORITY	MISSION/PURPOSE	# OF MEM.	MEMBER COMPOSITION	APPOINTMENT AUTHORITY	MEETINGS
Commonwealth Neurotrauma Initiative Advisory Board	§§ 2.1-1.6 and 32.1-73.1 through 32.1-73.4	Prevent traumatic spinal cord or brain injuries and improve treatment and care of Virginians with these conditions.	7	1 licensed practitioner w/ brain or spinal cord experience; 1 practitioner licensed by health regulatory board w/ brain or spinal cord injury rehabilitative program or services experience; 1 w/ a traumatic spinal cord injury or caretaker thereof; 1 w/brain injury or caretaker thereof; 1 citizen-at-large; the State Health Commissioner and the Commissioner of Rehabilitative Services or their designees. (The initial members of this Board, which was created by the 1997 General Assembly, have not yet been appointed.)	Governor	Unknown

16

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
3600 West Broad Street, Richmond, Virginia 23230-4917
Telephone: (804) 367-8500 TDD: (804) 367-9753
http://www.state.va.us/dpor

JACK E. KOTVAS
DIRECTOR

DEPUTY DIRECTOR:
JAMES L. GUFFEY
Enforcement

MEMORANDUM

TO: The Honorable Robert C. Metcalf
Secretary of Health and Human Resources

FROM: Jack E. Kotvas, Director
Department of Professional and Occupational Regulation

COPY: The Honorable Robert T. Skunda
Secretary of Commerce and Trade

Bobbie Jo Jonas
Department of Medical Assistant Services (DMAS)

Jeff Wilson
Office of the Secretary of Health and Human Resources

David E. Dick, Assistant Director
Department of Professional and Occupational Regulation

Nancy T. Feldman, Assistant Director
Department of Professional and Occupational Regulation

DATE: July 28, 1997

SUBJECT: Senate Joint Resolution 317 -- Study of Health Care Related Boards

David Dick, assistant director of the Department of Professional and Occupational Regulation, has been appointed the lead staff person in this department to work with others designated in order to complete the project established by Senate Joint Resolution 317.

Attached you will find our suggestions as to revisions and additions that should be made to update Appendix B of Senate Document Number Eight. We have two programs that would possibly be related to this study. One has been noted in Appendix B, "Opticians." The other, which should be added, is "Hearing Aid Specialists."

Since opticianry directly relates to the practice of optometry and ophthalmology, it should be considered for movement to the Department of Health Professions. In addition, since the practice of fitting and marketing hearing aids directly relates to the practice of audiology and otolaryngology, it should also be considered for movement to the Department of Health Professions. Please advise if any additional information about these programs is needed.

JEK/scp

Attachment

APPENDIX B

HEALTH CARE-RELATED BOARDS, COMMISSIONS, COMMITTEES, AND COUNCILS ESTABLISHED BY LAW

er Boards, Commissions, Committees, and Councils (cont'd)

ENTITY	CODE AUTH.	MISSION/ PURPOSE	# OF MEM	MEMBER COMPOSITION	APPOINT. AUTHORITY	MEETINGS
rd for icians* 94	§ 54.1-1703	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	5	3 opticians; 1 ophthalmologist; and 1 citizen	Governor	Three per year
rd for ring Aid cialists**	§ 54.1-1502	Establish qualifications for registration, certification or licensure; examine applicants; register/certify/license qualified applicants; levy and collect fees; promulgate regulations; and take disciplinary actions	7	4 licensed hearing aid specialists (one of which must also be a licensed audiologists), 1 otolaryngologist, and two citizens	Governor	Three per year

pticianry directly relates to the practice of optometry and ophthalmology. Both the Board for Optometry and the Board for Ophthalmology are d at the Department of Health Professions.

he fitting and selling of hearing aids directly relates to the practice of audiology and otolaryngology, both of which are regulated by boards located Department of Health Professions.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

TIMOTHY A. KELLY, Ph. D.
COMMISSIONER

P. O. BOX 1797
RICHMOND, VA 23214
(804) 786-3921
(804) 371-8977 VOICE/TDD

MEMORANDUM

TO: **Paulette Parker**
Center for Public Policy Research

FROM: **Timothy A. Kelly** TAK

RE: **Boards and Commissions**

DATE: **September 3, 1997**

In its review of Boards and Commissions, the Joint Commission on Healthcare identified three entities affiliated with the Department of Mental Health, Mental Retardation and Substance Abuse Services: (1) the State Mental Health, Mental Retardation and Substance Abuse Services Board; (2) the Alzheimer's Disease and Related Disorders Commission; and (3) the Governor's Council on Alcohol and Drug Abuse Problems. In addition, you have requested that the Department provide information on the Virginia Council on Coordinating Prevention.

State Mental Health, Mental Retardation and Substance Abuse Services Board. The State Board meets at least quarterly and frequently more often. It is an active policy-making body with a Board Administrator who is a member of the Commissioner's staff.

DMHMRSAS Recommendation: Continue the role and function of the State Board.

Alzheimer's Disease and Related Disorders Commission. The membership of this Commission has not been appointed in the past 4 years. The Commission has not met during that time period. When the Commission was active, it was staffed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). In response to a request from Thelma Bland, Commissioner, Department for the Aging, a former Commission member, Marilyn Maxwell, submitted

information about the role of the Commission and suggestions for future consideration. (See enclosed material).

DMHMRSAS Recommendation: The Alzheimer's Commission was a vehicle for coordinating administrative and legislative issues. If it is not feasible to reestablish the Commission, its functions could be assumed by the agencies (DMHMRSAS and Aging), with direction from the Secretary. In addition, as state policy on long-term care is developed in coordination with the Joint Commission on Healthcare, Alzheimer's issues should be a part of that policy and any interagency coordinating efforts that result.

Governor's Council on Alcohol and Drug Abuse Problems. The membership of the Governor's Council was appointed by Governor Allen, and staff assistance was designated in the Office of the Secretary of Public Safety. However to the knowledge of staff of DMHMRSAS, the Council has not been active in the past four years. Recently, the Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services (HJR 240) received presentations by various organizations, including the Virginia Association of Community Services Boards (VACSB) and the Virginia Association of Drug and Alcohol Programs (VADAP) calling for the revitalization of the Governor's Council. The VACSB recommends that the Department's responsibility for interagency coordination be strengthened and that the *Code* provisions (Chapter 11 of Title 37.1, §§ 37.1-203--37.1-224) be enforced. VADAP recommends that legislation be enacted to revise § 37.1-207, Governor's Council. The proposal calls for having the Chair of the Council become a full-time paid position with appropriate staff. The organization recommends that the Department of Transportation be deleted from the membership of the Council because the Virginia Alcohol Safety Action Program is no longer under VDOT. Membership of the Council should be only from the Departments that provide substance abuse services (DMHMRSAS, Department of Corrections, Department of Social Services, Department of Education, Department of Juvenile Justice Services, etc.). VADAP also recommends that membership should include statewide consumer and advocacy organizations. VADAP recommends that legislative membership be mandated, with one member from the House of Delegates and one member from the Senate and for the Council to meet at least six times annually, with additional full Council meetings and subcommittee meetings as needed and fully authorized by the Chair. As set forth in the *Code*, the Council would review and evaluate all substance abuse service resources and programming requests and coordinate services among agencies.

The Joint Subcommittee will be considering these recommendations in making its final report to the General Assembly in 1998.

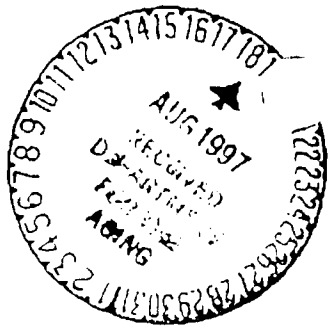
DMHMRSAS Recommendation: In view of the current emphasis on coordination of substance abuse services among agencies, particularly treatment and public safety agencies, reestablishment of the Council could help provide an important coordination function to ensure the most efficient and effective use of resources.

Virginia Council on Coordinating Prevention (VCCP). The VCCP has not been active in the past four years. A summary of the Council's history is enclosed. The Prevention Advisory Committee which reports to the State MHMRSAS Board has recommended to the State Board that VCCP be fully implemented as outlined in the *Code*. In addition, the Prevention Task Force of VACSB has recommended to the Substance Abuse Workgroup of HJR 240 that full implementation of VCCP occur. The HJR 240 Workgroup, chaired by Delegate Frank Hall has adopted this recommendation.

DMHMRSAS Recommendation: Because prevention and substance abuse issues involve a diversity of state, local and private sector entities, coordination efforts are essential. Since the statutory authorization for VCCP exists, the Council could be reinstated, or with the direction of the Secretary, DMHMRSAS could serve as the vehicle for coordination.

Mountain Empire Older Citizens, Inc.

AREA AGENCY ON AGING AND PUBLIC TRANSIT PROVIDER
SERVING COUNTIES OF LEE, WISE, SCOTT, AND THE CITY OF NORTON



TO: Thelma Bland

FROM: Marilyn Maxwell

RE: Role of Alzheimer's Commission

DATE: August 14, 1997

Enclosed is some information from old files during the time I served on the Governor's Commission on Alzheimer's Disease and Related Disorders. The first sheet lists the membership. It would be good for you to contact others for their opinions.

I believe that there is a need for a Governor's Commission on Alzheimer's Disease and Related Disorders and that it should report directly to the Secretary of Health and Human Resources. If the Commission is to be assigned for staff support to a state agency, I believe that the Virginia Department for the Aging is the most appropriate location.

Because of the work of the Commission, there are state funds for Respite Services for Alzheimer's family caregivers. That program is now at V.D.A. and desperately needs increased funding. Family Support Services is a major interest of the Commission.

I believe that the Commission must be independent from any other Board, the politics of all state government departments, and the pet research projects of any state college or university. It must focus on state policy and program issues, have representatives of families and local services, have freedom to comment on and evaluate issues impacting Alzheimer's patients and their families, conduct public hearings, be geographically representative, and carry out study assignments made by the General Assembly.

I do not think the Commission would function as responsibly and effectively as a sub-committee of an existing Board appointed by the Governor. These appointments are by and large made for political reasons. The beauty of the Alzheimer's Commission is the requirement for the various categories of membership.

If I think of other points, I'll pass them on to you. Thanks for asking.

MPM/jg

P.O. Box 888 ● Big Stone Gap, Virginia 24219

SUMMARY OF THE VIRGINIA COUNCIL ON COORDINATING PREVENTION (VCCP)

urpose To provide leadership and articulate a broad prevention agenda for the Commonwealth.

Legislation *1987 Code of Virginia, Chapter 219 ; 1989 Code of Virginia, Chapter 30, Section 9-267-9.273; 1991 Code of Virginia, Chapter 563, Section 9-270; 1992, Chapter 627*

Structure Shall meet twice/year; 18 members:

- twelve representatives of the governing or advisory boards of twelve state agencies, [see attached list] appointed by their board or council chair; not to serve more than two terms;
- five representatives of the private sector who are interested in prevention, appointed by the Governor;
- One *ex officio* member, the Secretary of Health and Human Resources;
- Governor appoints chairman from the membership of the council; *(however, the past two Secretaries have served as Chairmen.)*

Members shall be reimbursed for "reasonable and necessary expenses incurred in the performance of their duties."

Powers and Duties *(1991 Code of Virginia Section 9-270)*

- To review and comment on the Comprehensive Prevention Plan;
- Recommend to the Governor policies, legislation, regulations and funding to further the purposes of the Council and local prevention programs;
- Recommend prevention issues to be addressed by both public and private sectors;
- Recognize outstanding prevention programs;
- Recommend methods by which the Commonwealth my provide technical assistance and training to state, local, public and private agencies and individuals to promote the development and implementation of prevention initiatives;
- Develop recommendations for the establishment and operation of an information clearinghouse;
- Recommend data collection methods on program effectiveness;
- ". . .Council shall consider prevention activities. . . to be those governmental and private sector programs/services which **promote the maximum independence** of individuals and strengthen families; which avoid or minimize physical or mental disability or dysfunction; which **reduce the likelihood of dependence on governmental or private sector support,** treatment and rehabilitative services; and which **encourage future cost savings** through early intervention or treatment."

Additional Duties Upon the dissolution of the Department for Children (DFC) in 1991, the following duties were added to the VCCP *(1991, Virginia Code, Section 9-270.1)*:

- To develop a program to inform the public and professionals who work with children, of the state and local services available to children;
- To aid in the provision of technical assistance and training in support of efforts to initiate or improve programs and services for children, and
- To assist in the planning of children's services and to facilitate the exchange of information and ideas on children's issues.
- **Employ staff as necessary to carry out its duties** *(added in 1992, 9-270)*
- No agency is designated in the Code to "house" the VACCP. There is no direct reference in the Code to funding for the Council.

Comprehensive Prevention Plan for Virginia

(Section 9-271 Code of Virginia 1989)

- A "comprehensive prevention plan is to be jointly developed bienially by the following agencies. . . " *(this is a different group of people than is on the Council)*; and
- that"**the Secretary of Health and Human Resources shall designate an agency to coordinate development of the plan.**"
- Plan will include **cost analysis** and **be submitted to the House Committee on HWI, and the Senate Committees on Rehabilitation and Social Services and Education and Health for the purpose of analysis, review and comment prior to implementation** *(added 1992)*;
- 1st Plan covers 1990-1992;
- 2nd (and last) Plan covers 1992-2000.

Staff Support

- By memo from Howard Cullum to King Davis (4/8/91): "the Council will be coordinated, to include supervision of Council staff and program management, by the Director of the Office of Prevention, Promotion and Library Services [former name of the Office of Prevention] of DMHMRSAS";
- The Council coordinator was Ron Collier in the Office of Prevention; Mr. Collier's position was eliminated in July 1994.

Relevant History:

DPB Study

- On December 3, 1992, the Department of Planning and Budget issued a "Study of Prevention and Early Intervention (called the DPB Study), which "recommended that the state move toward implementing a comprehensive service system which places major emphasis on the prevention and early intervention end of the service delivery continuum";
- Recommended the organizational structure of the Comprehensive Services Act as the most appropriate way to coordinate prevention and early intervention services.

Prevention/ Early Intervention Project

- In response to the DPB study, Secretary Cullum assigned the Council on Coordinating Prevention, at their April 16, 1993 meeting , the responsibility of developing a process to examine ways to improve prevention planning and services in the Commonwealth (called the "Prevention/Early Intervention Project");
- Process recommended that the State Executive Council hire lead staff to coordinate the P/EI Study; Dr. Ellie Cobb was hired and reports to Commissioner Carol Brunty, who is chair of the SEC.

Council Suspends Activities

- At their June 3, 1993 meeting, the VCCP approved a proposed process; on June 9, 1993, their report on a recommended process was fowarded to Secretary Cullum;
- VCCP did not include any recommendations about their own role in this process; and
- they decided to suspend Council activities until completion of the Prevention/Early Intervention Study.

Decision Brief to Dr. Kelly re: the VCCP

- With the elimination of Mr. Collier's position in July 1994, the Office of Prevention no longer had a position to staff the VCCP;
- In a September 1, 1994 Decision Brief to Dr. Kelly, the Office of Prevention Services recommended that any decision on the VCCP be delayed until the Prevention Early Intervention Project completed its report and made recommendations regarding VCCP. Dr. Kelly approved.

State Agency Board Members on VCCP:

One member each from each (to be appointed by the chairman of the respective board or council):

- the Advisory Board for the Aging,
- Council on Child Day Care and Early Childhood Programs
- Board of Correctional Education
- State Board of Corrections
- State Board of Youth and Family Services
- Criminal Justice Services Board, State Board of Education, State Board of Health
- Board of Medical Assistance Services
- State Mental Health, Mental Retardation and Substance Abuse Services Board
- Virginia Board for People with Disabilities and Board of Social Services

Bienial Comprehensive Prevention Plan :

To be jointed developed by the following agencies:

- Department for the Aging
- Council on Child Day Care and Early Childhood Programs
- Department of Correctional Education
- Department of Corrections
- Department of Youth and Family Services
- Department of Criminal Justice Services
- Department of Education
- Department of HEalth
- Department of Medical Assistance Services
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department for Rights of Virginians with Disabilities
- Department of Social Services

Secretary designates lead agency to coordinate development of plan.

COMMONWEALTH of VIRGINIA

Department of Health

RANDOLPH L. GORDON, M.D., M.P.H.
COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

September 4, 1997

Paulette Parker
Center for Public Policy Research
The College of William and Mary
Post Office Box 8795
Williamsburg, Virginia 23187-2390

Dear Ms. Parker:

In conjunction with your efforts related to SJR 317, the study of boards, commissions, committees, and councils identified by the Joint Commission on Health Care (JCHC), I am pleased to provide you with some additional information which you may find useful. This information supplements that which was provided to the Secretary of Health and Human Resources with my July 18, 1997, memorandum to him.

Please note that the accompanying chart includes one additional entity, the Radiation Advisory Board, which was not included in the original JCHC list.

I urge you to contact my office if you have questions or if I may be of further assistance.

Sincerely,

Randolph L. Gordon, M.D., M.P.H.
State Health Commissioner

Attachment

Coordination within VDH

Q - Is the make-up of the State Board of Health reflective of the various boards, committees, councils, etc. that are related to it, or under it and which report to it? What can be done to improve coordination with these bodies?

Entity	Code Authority	Type	BOH Representation (Potential)
State Emergency Medical Services Advisory Board	§32.1-111.10	Advisory	MSV (2) Va. Nurses' Assoc. Hospital Industry Consumer (2)
Regional EMS Councils	§32.1-111.11	Policy	Local Gov't. MSV (2) Va. Nurses' Assoc. Hospital Industry
Financial Assistance and Review Committee	§32.1-111.12.01	Advisory	Varies according to composition of Regional EMS Councils
Virginia Health Planning Board	§32.1-122.02	Policy	Consumer (2) Hospital Industry Nursing Home Industry
Regional Health Planning Agencies/Boards	§32.1-122.05	Advisory	Consumer (2) MSV (2) Va. Nurses' Assoc. State Dental Assoc. Local Gov't.
Home Care Services Advisory Committee	§32.1-162.14	Advisory	Consumer (2) Va. Pharmaceutical Assoc.
Human Research Review Committees	§32.1-162.19	Advisory	Not specified

Hemophilia Advisory Board	§32.1-89	Advisory	Hospital Industry MSV (2) Consumer (2)
State Health Department Sewage Handling and Disposal Appeal Review Board	§32.1-166.1	Advisory	Consumer (2)
Virginia Voluntary Formulary Board	§32.1-80	Policy	MSV (2) Va. Pharmaceutical Assoc. State Dental Assoc. Consumer (2)
State Child Fatality Review Team	§32.1-283.1	Advisory	MSV (1)
AIDS Advisory Board	§32.1-11.1	Advisory	Not specified
Nursing Scholarships Advisory Committee	§23-35.9	Advisory	Va. Nurses' Assoc.
Radiation Advisory Board	§32.1-233	Advisory	MSV (1)
Virginia Transplant Council	§2.1-1.7(B) §32.1-297.1	Advisory	Hospital Industry
Commonwealth Neurotrauma Initiative Advisory Board*	**§32.1-73.3**	**Advisory**	**Consumer (1)**

* Bold type indicates newly established by the 1997 Virginia General Assembly

A - Based on the preceding chart, it appears that of the 16 referenced entities, 13 specify members who have counterparts on the State Board of Health (e.g., the hospital industry has representatives on 5 of these bodies). What is not known is the extent to which these representatives are aware that the State Board of Health also has such representatives appointed to it and with whom they could be sharing information and communicating concerns.

Recommendation - The chairman of the State Board of Health should correspond with the chairmen of each of these entities, advising them of the Board's interest in fostering improved communication and coordination with them, and providing them with a copy of the Board's roster so that this can be readily facilitated. To the extent that it is not already being done, the chairman should also invite a representative of each of these bodies to appear before it on a regular basis to update the Board regarding its activities and priorities.

Collaboration with Other Agencies

Q - Is there a need to have members from the boards of other health-related agencies (e.g. DHP's Board of Medicine, DMAS, DMHMRSAS) sit on the State Board of Health (and vice versa) in order to promote cross fertilization of ideas and complementary policies?

A - In the absence of a viable Virginia Health Planning Board, it would be worth exploring such an arrangement. Such individuals could function as informal liaisons between such bodies rather than being appointed in an ex officio capacity.

Recommendation - The Secretary of Health and Human Resources should initiate discussions with the appropriate agency heads to determine their willingness to explore such arrangements, if only on a pilot basis.

Composition of the State Board of Health

Q - Does the current make-up of the State Board of Health satisfactorily encompass the representation needed to effect policy in today's changing health care market?

A - It would appear that with the expansion of managed care as the new model for the health care delivery system, there is a need to consider expansion of the State Board of Health to include a representative of a health maintenance organization and/or other type of health insurance organization (e.g., PPO). There may also be other interests (e.g., environmental) which merit representation on the Board.

Recommendation - Initiate an analysis of other states' boards of health to determine the kinds of representation they reflect. On the basis of this study develop recommendations regarding the composition of our State Board of Health for review by the Governor's office.

Appendix 6. Number of Recent Meetings for Each Board by Agency Affiliation

Entity	Zero	One or Two	Three or Four	Five or More	Variable	Unknown
Department of Health						
Board of Health			X			
State Emergency Medical Services Advisory Board				X		
Regional Emergency Medical Services Councils					Varies among the 8 regional EMS Councils	
Financial Assistance & Review Committee				X		
Virginia Health Planning Board	None in several years					
Regional Health Planning Agencies/Boards					Varies among the 5 regional boards	
Home Care Services Advisory Committee	Has not met in 10 years					
Human Research Review Committees	Inactive					
Hemophilia Advisory Board		X				
Sewage Handling & Disposal Appeal Review Board				X		
Virginia Voluntary Formulary Board			X			
State Child Fatality Review Team				X		
AIDS Advisory Board	Inactive					
HIV Community Planning Committee				X		
AIDS Drug Assistance Program			X			
Nursing Scholarships Advisory Committee		X				
Virginia Transplant Council			X			
Commonwealth Neurotrauma Initiative Advisory Board						Not yet applicable
Radiation Advisory Board						X

Appendix 6. Number of Recent Meetings for Each Board by Agency Affiliation

Entity	Zero	One or Two	Three or Four	Five or More	Variable	Unknown
Department of Health Professions						
Board of Health Professions			X			
Board of Audiology and Speech Pathology			X			
Board of Dentistry			X			
Board of Funeral Directors and Embalmers			X			
Board of Medicine			X			
Psychiatric Advisory Board	X					
Advisory Board on Physical Therapy			X			
Advisory Board on Respiratory Therapy			X			
Advisory Board on Occupational Technology			X			
Advisory Committee on Radiological Technology		X				
Advisory Committee on Acupuncture		X				
Board of Nursing				X		
Board of Optometry				X		
Board of Pharmacy				X		
Intervention Program Committee						Not yet applicable
Board of Licensed Professional Counselors, Marriage & Family Therapists, & Substance Abuse Professionals			X			
Board of Psychology				X		
Advisory Committee on Certified Practices	None in 1997					
Advisory Board on Rehabilitation Providers			X			

Appendix 6. Number of Recent Meetings for Each Board by Agency Affiliation

Entity	Zero	One or Two	Three or Four	Five or More	Variable	Unknown
Board of Social Work				X		
Board of Veterinary Medicine				X		
Department of Medical Assistance Services						
Board of Medical Assistance Services				X		
Advisory Committee on Medicare & Medicaid	None since 6/91					
Medicaid Prior Authorization Advisory Committee	X					
Indigent Health Care Trust Fund Technical Advisory Panel		X				
Medicaid Pharmacy Liaison Committee						X
Department of Mental Health, Mental Retardation and Substance Abuse Services						
State Mental Health, Mental Retardation and Substance Abuse Services Board			X			
Alzheimer's Disease and Related Disorders Commission	None for approximately 4 years					
Governor's Council on Alcohol and Drug Abuse Problems	None for approximately 4 years					
Department of Rehabilitative Services						
Board of Rehabilitative Services			X			
Statewide Rehabilitation Advisory Council			X			
Statewide Independent Living Council			X			
Disability Services Council			X			
Virginia Council on Assistive Technology			X			

Appendix 6. Number of Recent Meetings for Each Board by Agency Affiliation

Entity	Zero	One or Two	Three or Four	Five or More	Variable	Unknown
Department of Personnel and Training						
Local Health Benefits Advisory Committee		X				
State Health Benefits Advisory Council		X				
Secretary of Health and Human Resources						
Maternal and Child Health Council						X
Virginia Board for People with Disabilities			X			
Department for Rights of Virginians with Disabilities						
Protection and Advocacy for Individuals with Mental Illness Council				X		
Department for the Visually Handicapped						
Virginia Board for the Visually Handicapped			X			
Statewide Rehabilitation Advisory Council for the Blind			X			
Joint Advisory Board for the Industries for the Blind						
Department for the Deaf and Hard of Hearing						
Advisory Board for the Dept. of the Deaf and Hard-of-Hearing			X			
Interagency						
State Executive Council for At-Risk Youth and Families				12		
Virginia Council on Coordinating Prevention	None for approximately 7 years					

Appendix 6. Number of Recent Meetings for Each Board by Agency Affiliation

Entity	Zero	One or Two	Three or Four	Five or More	Variable	Unknown
Interagency Coordinating Council on Housing for the Disabled						X
Interagency Migrant Worker Policy Committee				X		
Department of Social Services						
Board of Social Services				X		
Advisory Board on Child Abuse and Neglect						X
Department for the Aging						
Advisory Board for the Department for the Aging			X			
Long-Term Care Council	Expired 7/1/95					
Specialized Transportation Council	None in the past year					
Specialized Transportation Technical Advisory Committee	None for approximatey 3 years					
Department of Education						
School Health Advisory Boards					Varies, but many meet a minimum of 4 times a year	
Department of Professional and Occupational Regulation						
Board for Opticians			X			
Board for Hearing Aid Specialists			X			
Bureau of Insurance						
Special Advisory Commission on Mandated Health Insurance Benefits			X			
Department of Labor and Industry						
Safety and Health Codes Board		X				

Appendix 6. Number of Recent Meetings for Each Board by Agency Affiliation

Entity	Zero	One or Two	Three or Four	Five or More	Variable	Unknown
Migrant and Seasonal Farmworkers' Board			X			
Department of Motor Vehicles						
Medical Advisory Board for the Department of Motor Vehicles			X			
Virginia Birth-Related Neurological Injury Compensation Fund				X		

SOURCE: Center for Public Policy Research, Thomas Jefferson Program in Public Policy, College of William and Mary, September 1997.

Appendix 7.
Agency Contacts for Georgia, Maryland, North Carolina and Ohio

State/Contact Person	Organization
Georgia	
James Ledbetter	Georgia Coalition for Health, Inc.
Marjorie Young	Department of Human Resources
Maryland	
Barbara Shipnuck	Department of Health and Mental Hygiene
Ronald Sundergill	Department of Human Resources
North Carolina	
Chris Hoke	Department of Environment, Health and Natural Resources
June Milby	Department of Human Resources
Ohio	
Ronald Elbe	Ohio Department of Health
Lorin Ranbom	Ohio Department of Human Resources
Pennsylvania	
Peg Dreikers	Secretary of Public Welfare
William Wiegmann	Secretary of Health

SOURCE: Center for Public Policy Research, The Thomas Jefferson Program in Public Policy, College of William and Mary

Appendix 8. Internet Sites Used to Research Health Care Organizations in Georgia, Maryland, North Carolina and Ohio

State	Internet Site
Georgia	www.state.ga.us
Maryland	www.mec.state.md.us/mec
North Carolina	www.sips.state.nc.us
Ohio	www.state.oh.us

Appendix 9. Membership Profile of Health Care-Related Boards by Agency Affiliation

Board and Agency Affiliation	Consumers*	Citizens At-Large*	Professionals	Inter-Agency Representation	Intra-Agency Representation	Regional Representation
DEPARTMENT OF HEALTH (DOH)						
Board of Health Members: 11	2		9			
State Emergency Medical Services Advisory Board Members: 24	1		13			8
Regional Emergency Medical Services Councils Members: Variable			X**			X
Financial Assistance & Review Committee Members: 6						6
Virginia Health Planning Board Members: 18	8		4	6		
Regional Health Planning Agencies/Boards Members: <30	X		X	X		
Home Care Services Advisory Committee Members: 10		2	4	4		
Human Research Review Committees Members: N/A						
Hemophilia Advisory Board Members: 7		1	6			
Sewage Handling & Disposal Appeal Review Board Members: 7			7			
Virginia Voluntary Formulary Board Members: 12		1	11			
State Child Fatality Review Team Members: 16			11	5		
AIDS Advisory Board Members: N/A						
HIV Community Planning Committee Members: 31	X	X	X			
AIDS Drug Assistance Program Members: 16	X		X			
Nursing Scholarships Advisory Committee Members: 8			8			
Virginia Transplant Council Members: 18			18			
Commonwealth Neurotrauma Initiative Advisory Board Members: 7	2	1	4			
Radiation Advisory Board Members: 10			10			

Appendix 9. Membership Profile of Health Care-Related Boards by Agency Affiliation

Board and Agency Affiliation	Consumers*	Citizens At-Large*	Professionals	Inter-Agency Representation	Intra-Agency Representation	Regional Representation
DEPARTMENT OF HEALTH PROFESSIONS (DHP)						
Board of Health Professions Members. 17	5		12			
Board of Audiology and Speech Pathology Members: 7		2	5			
Board of Dentistry Members: 10		1	9			
Board of Funeral Directors and Embalmers Members: 9		2	7			
Board of Medicine Members: 17		2	4			11
Psychiatric Advisory Board Members: N/A						
Advisory Board on Physical Therapy Members: 5			5			
Advisory Board on Respiratory Therapy Members: 5		1	4			
Advisory Board on Occupational Technology Members: 5		1	4			
Advisory Committee on Radiological Technology Members: 29			5		1	
Advisory Committee on Acupuncture Members: 7			6		1	
Board of Nursing Members: 13		3	10			
Board of Optometry Members: 6		1	5			
Board of Pharmacy Members: 10		2	8			
Intervention Program Committee Members: 7			7			
Board of Licensed Professional Counselors, Marriage & Family Therapists, & Substance Abuse Professionals Members: 14		2	12			
Board of Psychology Members: 9		2	7			
Advisory Committee on Certified Practices Members: 10			8		2	

Appendix 9. Membership Profile of Health Care-Related Boards by Agency Affiliation

Board and Agency Affiliation	Consumers*	Citizens At-Large*	Professionals	Inter-Agency Representation	Intra-Agency Representation	Regional Representation
Advisory Board on Rehabilitation Providers Members: 10			8		2	
Board of Social Work Members: 7		2	5			
Board of Veterinary Medicine Members: 7		1	6			
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)						
Board of Medical Assistance Services Members: 11		6	5			
Advisory Committee on Medicare & Medicaid Members: 21	X		X	X	X	
Medicaid Prior Authorization Advisory Committee Members: 11	2		9			
Indigent Health Care Trust Fund Technical Advisory Panel Members: 15			9	2	4	
Medicaid Pharmacy Liaison Committee Members: 5			5			
DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION & SUBSTANCE ABUSE SERVICES (DMHMRSAS)						
State Mental Health, Mental Retardation and Substance Abuse Services Board Members: 9		4	5			
Alzheimer's Disease and Related Disorders Commission Members: 14	X		X			
Governor's Council on Alcohol and Drug Abuse Problems Members: 19		X	X	X		
DEPARTMENT OF REHABILITATIVE SERVICES (DRS)						
Board of Rehabilitative Services Members: 9	4		5			
Statewide Rehabilitation Advisory Council Members: 22	12		10			
Statewide Independent Living Council Members: 14			X			

Appendix 9. Membership Profile of Health Care-Related Boards by Agency Affiliation

Board and Agency Affiliation	Consumers*	Citizens At-Large*	Professionals	Inter-Agency Representation	Intra-Agency Representation	Regional Representation
DEPARTMENT OF REHABILITATIVE SERVICES (DRS) (continued)						
Virginia Council on Assistive Technology Dept. of Rehabilitative Services Members: 18	15		3			
DEPARTMENT OF PERSONNEL AND TRAINING (DPT)						
Local Health Benefits Advisory Committee Members: 7	X	X	X			
State Health Benefits Advisory Council Members: 17	13	4				
SECRETARY OF HEALTH AND HUMAN RESOURCES						
Maternal and Child Health Council Members: 16			11	5		
VIRGINIA BOARD FOR PEOPLE WITH DISABILITIES Members: 40	31			9		
DEPARTMENT for RIGHTS of VIRGINIANS WITH DISABILITIES						
Protection & Advocacy for Individuals with Mental Illness Council Members: 20	11		9			X
DEPARTMENT FOR THE VISUALLY HANDICAPPED						
Virginia Board for the Visually Handicapped Members: 7	4		3			
Statewide Rehabilitation Advisory Council for the Blind Members: 16	5		10	1		
Joint Advisory Board for the Industries for the Blind Members: 9	2		7			
DEPARTMENT FOR THE DEAF AND HARD OF HEARING						
Advisory Board for the Dept. of the Deaf and Hard-of-Hearing Members: 9	9					

Appendix 9. Membership Profile of Health Care-Related Boards by Agency Affiliation

Board and Agency Affiliation	Consumers*	Citizens At-Large*	Professionals	Inter-Agency Representation	Intra-Agency Representation	Regional Representation
INTERAGENCY						
State Executive Council for At-Risk Youth and Families Members: 7	1			6		
Virginia Council on Coordinating Prevention Members: 18					18	
Interagency Coordinating Council on Housing for the Disabled Members: 10				10		
Interagency Migrant Worker Policy Committee Dept. of Labor and Industry Members: 17				17		
DEPARTMENT OF SOCIAL SERVICES						
Board of Social Services Members: 9						9
Advisory Board on Child Abuse and Neglect Members: 16			10	6		
DEPARTMENT FOR THE AGING						
Advisory Board for the Department for the Aging Members: 23	23					X
Specialized Transportation Council Members: 10	3		5	2		
Specialized Transportation Technical Advisory Committee Members: 12			X	X	X	X
DEPARTMENT OF EDUCATION						
School Health Advisory Boards Members: <20						X
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION						
Board for Opticians Members: 5		1	4			
Board for Hearing Aid Specialists Members: 7		2	5			

Appendix 9. Membership Profile of Health Care-Related Boards by Agency Affiliation

Board and Agency Affiliation	Consumers*	Citizens At-Large*	Professionals	Inter-Agency Representation	Intra-Agency Representation	Regional Representation
BUREAU OF INSURANCE						
Special Advisory Commission on Mandated Health Insurance Benefits Members: 14	2		10	2		
DEPARTMENT OF LABOR AND INDUSTRY						
Safety and Health Codes Board Members: 14		X	X			
Migrant and Seasonal Farmworkers' Board Members: 15						15
DEPARTMENT OF MOTOR VEHICLES						
Medical Advisory Board for the Department of Motor Vehicles Members: 7			7			
VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM Members: 7		3	4			

* The distinction between consumers and citizens appears in the "Member Composition" column of Table 1. Consumers are those who have some interest in the mission of a particular board, and/or may be recipients of the services overseen by that board. Citizens are individuals who have no evident direct connection to the work or mission of the board on which they serve.

** An "X" signifies that there are members of this Board in this category. However, some members may belong to more than one constituency category. In these cases, their representation is denoted with an "X."

Appendix 10. Critical Issues in Virginia Health Care[1]

I. Technology and Research

*Improve the security and accuracy of data networks, including the internet
*Update technology and aging infrastructure
*Maximize use of telemedicine
*Use assistive technology to put people with disabilities to work
*Improve data collection and data quality efforts
*Increase understanding of drug-resistant diseases; encourage development of new and better antibiotics

II. Education and Networking

*Expand prevention and health education
*Form partnerships between government programs and health care systems
*Improve programs addressing teen pregnancy and fatherhood
*Improve continuing education requirements for professionals
*Improve training of local entities of program features and responsibilities

III. Access to Health Care and Managed Care

*Improve access to quality care
*Increase involvement in managed care arena
*Refine projections of future, specifically with regard to long-term care alternatives

IV. Prevention

*Reduce the incidence of communicable diseases
*Improve focus on prevention of and protection from environmental health hazards
*Evaluate potential risks of unregulated alternative medicine
*Empower individuals with disabilities
*Keep people off welfare
*Improve family support systems
*Focus on rights of institutionalized persons

V. Strategic Planning

*Improve quality of oversight of health care
*Control increasing need for investigations, reviews and audits
*Increase staffing to meet increased demand for licenses and certifications
*Increase utilization review to follow-up on care
*Link program funding with performance
*Redefine role of existing facilities and systems
*Maximize use of services, increase services to meet increased needs

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[1] These Critical Issues were reported to the CPPR by the office of the Secretary of Health and Human Resources. The Critical Issues were communicated to HHR by the largest agencies in the Secretariat. The CPPR developed the categories, and placed the Issues in categories; none of the items in the original list were excluded or combined in what appears here.

Public Comments

The public comments that follow were made to a draft of this report. Following that draft and initial presentation of the draft to the Joint Commission on Health Care, the Center for Public Policy Research made appropriate revisions to the report based on responses from reviewers and interested parties regarding the Virginia Health Planning Board and Regional Health Planning Agencies/Boards.

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION

JACK B. KOTVAS
DIRECTOR

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DEPUTY DIRECTORS:
THOMAS A. GELOZIN
Administration & Finance
JAMES L. GUFFEY
Enforcement

MEMORANDUM

TO: Bobbie Jo Jonas, Department of Medical Assistance Services

FROM: David E. Dick, Assistant Director

COPY: Jack E. Kotvas, Director
Nancy Feldman, Assistant Director

PHONE: 367-8507

DATE: September 26, 1997

RE: SJR 317 Draft Report

We have reviewed the SJR 317 Draft Report you provided by memorandum dated September 22, 1997.

We agree with recommendation #5 on page 10.

I note one necessary correction. On page 35, the column headed "Required Meetings" indicates that the Board for Opticians and the Board for Hearing Aid Specialists are required to meet three times per year. Neither board's enabling statute sets a minimum of meetings per year. Both boards customarily meet three times per year at a minimum.

Please feel free to contact me if I may be of further assistance.

COMMONWEALTH of VIRGINIA

THELMA BLAND-WATSON
COMMISSIONER

Department for the Aging
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Richmond, VA 23229

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TTY (804) 662-9333
FAX (804) 662-9354
TOLL FREE (800) 552-3402

TO: Jane Kusiak, Director
Joint Commission on Health Care

FROM: Thelma Bland Watson Thelma Bland Watson

SUBJECT: Department Comments on SJR 317

DATE: October 15, 1997

Thank you for the opportunity to comment on Senate Joint Resolution 317. The Department for the Aging would like to clarify its relationship with the Specialized Transportation Council and the Specialized Transportation Technical Advisory Committee. The Council, established in Code of Virginia, § 9-320-325, is an independent body chaired by the Secretary of Health and Human Resources. The Vice Chair is the Secretary of Transportation and eight additional members are appointed by the Governor. Section 321 states that "Staff shall be provided by the Office of the Secretary of Health and Human Resources." At the request of the Secretary, the Department for the Aging has provided staffing since 1992.

In 1996, meetings were held on January 24, September 12 and November 13. A meeting in January, 1997, was canceled and no subsequent meetings were scheduled while a review of specialized transportation was conducted. Nevertheless, specialized transportation continues to be the lifeline to health and medical services for many Virginians, including some 300,000 elderly who do not have a drivers license, as well as thousands of young adults with mobility impairments and thousands more who are trying to move from welfare to work.

The Commonwealth spends over $50,000,000 annually on specialized transportation without any policy of coordination or cooperation among the several state agencies which pay for or provide it. The mission of the Council is to eliminate duplication and increase coordination at the local level. Therefore, the work of the Council is "vital to the health mission of the Commonwealth" as the only entity actively promoting and rewarding coordination of human services transportation.

Thank you again for the opportunity to provide comments. Please let me know if you need any additional information.

New River Valley Agency On Aging

141 EAST MAIN STREET
PULASKI, VIRGINIA 24301

(540) 980-7720 or 639-9677
FAX (540) 980-7724

October 29, 1997

The Honorable Stanley C. Walker, Chairman
Joint Commission on Health Care
1001 East Broad Street, Suite 115
Richmond, Virginia 23219

Dear Senator Walker:

I am writing to comment on SJR 317, the Secretary of Health and Human Resources' Study of Health -Related Boards, Commission and Councils. Specifically, I am deeply concerned that the Specialized Transportation Council (STC) and its Technical Advisory Committee have been listed as two of the six boards/councils to be eliminated.

The rationale for elimination of a board/council is that they are" no longer necessary-they are no longer functional and/or their missions are currently carried out by other boards in the commonwealth." I strongly disagree with the authors of this study when it comes to the elimination of the STC.

Much work needs to be done to make sure specialized transportation services are coordinated at the state & local levels. Many of the STC's responsibilities, listed below, are ongoing to make sure the Commonwealth is trying to meet the transportation needs of the thousands of Virginians who cannot drive and do not have access to public transportation.

The STC responsibilities are as follows:

1. Recommending strategies, standards, policies, and guidelines for the development of coordinated specialized transportation services for elderly persons and disabled persons;
2. Developing a comprehensive statewide specialized transportation plan based upon regional and local coordination of participating public transportation systems, private for-profit and nonprofit transportation providers, human service transportation providers, and local volunteer resources;
3. Developing criteria for and administering the Specialized Transportation Incentive Fund and other funds under its authority to fund innovative and coordinated specialized transportation planning and projects;
4. Identifying barriers to coordinated delivery of transportation services and recommending corrective actions;
5. Developing incentives for public-private partnerships;
6. Developing initiatives for eliminating constraints upon volunteers who provide transportation and recommending incentives for those volunteers:
7. Developing safety, maintenance and operational guidelines for human service transportation providers;

8. Composing and directing the work of a specialized transportation technical advisory committee; and
9. Advising and reporting to the Governor and the General Assembly annually on potential program and policy initiatives in specialized transportation. (1992, c.143.)

The Secretary of Health and Human Resources is to serve as the STC Chairman with the Secretary of Transportation serving as Vice-Chairman. The Governor appoints eight members total that include representatives of various transportation entities, three consumers and two at-large members. Staffing for the STC has been provided by the Virginia Department for the Aging.

I have been a member of the STC since its inception as a representative of rural transportation providers. I was originally appointed by Governor Wilder and was reappointed by Governor Allen. When the STC was first established, Secretary Howard Cullum had the STC meeting on a regular basis at sites throughout the State. We held public hearings to listen to the transportation needs of the elderly and disabled populations. We developed a "State Plan for Meeting the Transportation Needs of Virginians Who Cannot Drive" and we gave direction on awarding the Specialized Transportation Incentive Fund (the tax check-off fund). To say the least, the original STC was very active and worked to make transportation opportunities available to those unserved or underserved throughout the State.

During the current administration we have not been as active. This has not been due to the appointees and/or their desire to function. The Council members specifically asked that we be allowed to meet at least quarterly to continue our work. However, we have not been allowed to meet on a regular basis and, in fact, no meetings have been held since November of 1996.

The State of Virginia spends millions of dollars annually on specialized transportation. Who is working to make sure there is no duplication of efforts? Who is working to make sure there is coordination of transportation services? I would think that the Commonwealth would gladly allow the STC to function to make sure every effort is made at the state and local levels to use this huge amount of transportation resources to its maximum benefit.

I am sure that if the authors of this study had contacted the appointed members of the STC, they would have had an entirely different view of the STC's importance and potential effectiveness. I believe the STC appointees are more than willing to serve the State if only they would have been requested to meet.

I would strongly urge the Joint Commission on Health Care to continue the Specialized Transportation Council and its Technical Advisory Committee. I would also urge you to make sure that the Council has the opportunity to continue its work and that it meets on a regular basis.

Thank you for this opportunity to comment. Hopefully, by copy of this letter, I can inform other appointed STC members of this proposal to eliminate the Council and they also will have time to respond. Nevertheless, I can assure you that this Council can benefit the State and the thousands of older or disabled persons that need transportation services to be able to get food, go to the doctor, and in general, have the ability to meet their transportation needs.

Sincerely,

Debbie H. Palmer
Executive Director

DHP/jah
cc: Delegate Thomas G. Baker Jr.
Mr. Harris Spindle, V4A
Mr. Pete Geisen, V4A Legislation Coordinator
Current Appointees to the STC

TRANSPORTATION GENERAL, ® INC.

3251 WASHINGTON BOULEVARD
ARLINGTON, VIRGINIA 22201

(703) 525-0900

11/5

November 3, 1997

The Honorable Stanley C. Walker, Chairman
Joint Commission on Health Care
1001 East Broad Street, Suite 115
Richmond, VA 23219

Dear Senator Walker:

This is in regard to SJR317, the Secretary of Human Resources' Study of Health Related Boards, Commissions and Councils. My particular concern is the proposed elimination of the Specialized Transportation Council (STC) and its Technical Advisory Committee.

I have been a member of the STC as an at large representative since its inception, originally appointed by Governor Wilder and reappointed by Governor Allen. In its initial term, the Council was very active. The members participated in statewide meetings and public hearings which led to a "State Plan for Meeting the Transportation Needs of Virginias Who Cannot Drive" and the successful implementation of the Specialized Transportation Incentive Fund.

Subsequently, the Council has not been as active. While both long time and new members are willing and interested, and have asked for regular meetings, no meeting has been called since November of 1996.

I believe that there remains much work to be done in the area of specialized transportation, particularly in the coordination of the limited resources available. As a private, for profit transportation operator, I was impressed and gratified by the eagerness of the non-profit agencies and providers, as well as consumers, represented on the Council to work together to address these critical needs. I strongly believe that the interests of all Virginians are best served by the continuation and encouragement of the Council's efforts.

Thank you for your consideration of my views.

Very Truly yours,

Charles O. King
Vice President

NATIONAL · HEARING · AID · SOCIETY
CHAPTER

Virginia Society of Hearing Aid Specialists, Inc.

700 S. Sycamore Street — #15
Petersburg, VA 23803
(804) 733-8360

DONALD HALTLI
~~Teresa M. Robinson~~, BC-HIS
President

October 28, 1997

Jan Kusiak, Executive Director
Joint Commission on Health Care
Old City Hall
1001 East Broad Sttreet, Suite 115
Richmond, VA 23219

Dear Mr. Kusiak:

On behalf of the Virginia Society of Hearing Aid Specialists I appreciate the opportunity to comment on the recommendations in the study of health related boards.

In the report to the Joint Commission, the Center for Public Policy Research recommended moving the Board for Hearing Aid Specialists from the Department of Professional and Occupational Regulation to the Department of Health Professions. The center's report noted that the function of the Board is more closely aligned with health professions than with business.

We agree that licensed hearing aid specialists do provide citizens with health related care. Nonetheless, we have concern with the recommendation. As it stands, many crucial issues related to safety of the public are not addressed. For example, it does not consider whether the practical testing function performed by the hearing aid specialist licensing board would effectively transfer to a Department that, for the most part, has little experience with pracical testing.

While this recommendation may merit longer-term consideration we encourage the Joint Commission not to adopt it at this time. If the Joint Commission should decide to consider or study it over a longer period of time. VSHAS would welcome the opportunity to participate.

Thank you for your attention to this matter.

Sincerely,

Donald Haltli

Donald Haltli
President

DH:tmr

Virginia Association of Regional Health Planning Agencies

Central Virginia Health Planning Agency Eastern Virginia Health Systems Agency
Health Systems Agency of Northern Virginia Northwest Virginia Health Systems Agency Southwest Virginia Health Systems Agency

October 30, 1997

Stanley C. Walker, Chairman
Joint Commission on Health Care
1001 East Broad Street, Suite 115
Richmond, VA 23219

Dear Senator Walker:

The Virginia Association of Regional Health Planning Agencies is pleased to submit comments and observations on the **Study of Health Care-Related Boards in the Commonwealth of Virginia** (pursuant to SJR 317) conducted by the Center for Public Policy Research at the College of William and Mary. Our remarks specifically address, and are limited to, the Virginia Health Planning Board and Regional Health Planning Agencies/Boards.

The discussion of the Virginia Health Planning Board, though limited, appears to be generally accurate and the recommendation that the question of the future role of the Board and of how its prescribed functions can best be carried out be the subject of further study seems reasonable.

The discussion and treatment of Regional Health Planning Agencies/Boards too is brief; we regret that nonetheless it is also substantially inaccurate and misleading. The inaccuracies appear to result from the failure of the investigators to investigate, even cursorily, regional health planning agencies (RHPAs) and their activities. No regional agency was contacted by those conducting the study, nor was anyone in the Department of Health with whom we work.

I. Relationship to Virginia Health Planning Board

Had RHPAs, the Virginia Association of Regional Health Planning Agencies, or knowledgeable Department of Health officials been contacted, the investigators would have learned the following about RHPAs and their relationship to the Virginia Health Planning Board:

■ Virginia is divided into five health service areas; each is served by a regional health planning agency. The VHPB did designate (or recertify) the five health service areas and the Health Systems Agencies that serve those regions shortly after the Board was established, but RHPAs were not established or otherwise created by VHPB and are not structurally a part of the Board.

■ Each RHPA is a 501(C)(3) private, tax exempt, corporation which functions in accordance with applicable Virginia law and regulation (notably the Virginia Medical Facilities Certificate of Public Need law and the VHPB governing statute), its charter and bylaws.

■ VHPB never selected, appointed or otherwise determined RHPA membership, or other internal operations. RHPAs were established over twenty years ago, more than a decade before the VHPB came into existence.

■ RHPAs assisted, to the limit of their abilities, VHPB in the conduct of its health planing activities during the year that it operated, but never were dependent upon the Board or limited in their functions by the inactivity of VHPB.

II. Regional Health Planning Agency Vitality

The investigators would also have been informed that RHPAs are active, fully functional, and fulfilling in a timely and professional manner all responsibilities. Examples include:

■ Each RHPA contracts with the Commissioner of Health to undertake specified planning, regulatory, and data collection and analysis activities. These contracts are usually biennial, and specify the substantive and procedural roles and responsibilities of the respective parties. Apparently, the investigators were unaware of the history and the multifaceted roles of RHPAs.

■ Contrary to the referenced four to 12 meetings per year, RHPAs hold an average of between 30 and 40 formal business meetings per year, about one-half of which are advertized public hearings.

■ These meetings do not include the dozens of informal committee meetings and meetings with community groups and providers of health services, or meetings held every month of all the RHPAs, usually with Department of Health officials. The investigators were invited to an Association meeting (scheduled for October 10) after their report was presented but declined to attend.

■ In addition to basic community and regional planning activities, regional agencies record all public hearings and compile public records on all certificate of public need proposals. There is a continuous stream of written and electronic communications between RHPAs, the Department of Health, local governments, and other interested parties. To date, all RHPAs have fulfilled completely all responsibilities for which they have contracted with the Virginia Department of Health.

III. Necessity of Additional Study

Those conducting the study indicate that they were unable to determine how RHPAs and the Department of Health communicate and otherwise exchange data and critical information, and consequently that the issue requires further study. The investigators are unclear on these points only because of a general failure to inquire of either the RHPAs or Department of Health officials which whom the RHPAs work.. At noted above, written contracts and protocols exist, and there is a large and growing record that can be had with a telephone call There are literally

more than a dozen Department of Health officials who are intimately familiar with RHPA activities and functions. None were consulted. Failure to inform oneself about something, particularly about an entity that is wholly public and easily examined, seems hardly justification for recommending additional study.

Should the future of the VHPB be the subject of further study, RHPAs should be consulted and involved, at least indirectly, as a matter of course. We suggest that there is little need to expend additional resources to study RHPAs and that they be stricken from the investigators suggested list of entities requiring additional evaluation and review.

Sincerely,

Dean Montgomery
Virginia Association of Regional
Health Planning Agencies

cc: Jane Kusiak, Executive Director, JCHC
Joseph Teefey, Director, Virginia DMAS

VIRGINIA HOSPITAL
& HEALTHCARE
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October 29, 1997

Jane Kusiak
Executive Director
Joint Commission on Health Care
Old City Hall, Suite 115
1001 East Broad Street
Richmond, VA 23219

Subject: Comments – Secretary of Health and Human Resources' Study of Health-Related Boards, Councils and Commissions

Dear Ms. Kusiak:

The Virginia Hospital & Healthcare Association appreciates the opportunity to comment on the Secretary of Health and Human Resources' report on his study of health-related boards, commissions and councils. This study is essential to ensuring that the entities assisting state government in directing health policy are as productive as possible, functioning without duplication.

We generally concur with the recommendations contained in the report. We support the recommendation that incentives be created for networking and collaboration among existing boards. This has become more important with the complexities posed by new forms of health care delivery and financing.

We agree that it may be appropriate to eliminate the six boards identified in Recommendation A6, including the Department of Medical Assistance Services' Advisory Committee on Medicare and Medicaid. We also endorse further study of the effectiveness of the boards identified in Recommendation A8 to determine whether they should continue to function alone or consolidated with other boards.

This examination is a useful one that perhaps should be undertaken periodically.

Again we thank you for your attention to these comments.

Sincerely,

Katharine M. Webb

Katharine M. Webb
Senior Vice President

\\Va_Hospital\Sys\COMM\SUSANW\Jchcbrds.Doc